SERFF Tracking Number:	*MRKC-126858975*	*State:*	*Arkansas*
Filing Company:	*Markel Insurance Company*	*State Tracking Number:*	*47696*
Company Tracking Number:	*MAG300T-AR (01/11)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Markel Basic Health Insurance*		
Project Name/Number:	*Markel Basic Health Insurance/MAG300T-AR (01/11)*		

Filing at a Glance

Company: Markel Insurance Company

Product Name: Markel Basic Health Insurance	SERFF Tr Num: MRKC-126858975	State: Arkansas
TOI: H21 Health - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 47696
Sub-TOI: H21.000 Health - Other	Co Tr Num: MAG300T-AR (01/11)	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Katie Savino	Disposition Date: 02/08/2011
	Date Submitted: 01/13/2011	Disposition Status: Approved-Closed
Implementation Date Requested: 02/14/2011		Implementation Date:

State Filing Description:

General Information

Project Name: Markel Basic Health Insurance
Project Number: MAG300T-AR (01/11)
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Discretionary
Filing Status Changed: 02/08/2011
State Status Changed: 02/08/2011
Created By: Katie Savino
Corresponding Filing Tracking Number: MAG300T-AR (01/11)
PPACA: Not PPACA-Related
PPACA Notes: null
Filing Description:
Type of filing: New

Status of Filing in Domicile: Authorized
Date Approved in Domicile: 11/09/2010
Domicile Status Comments:
Market Type: Group
Group Market Size: Small and Large
Overall Rate Impact:

Deemer Date:
Submitted By: Carol Depuy

Forms submitted for approval: MAG300T-AR (01/11) - Arkansas Amendatory Endorsement

Forms submitted for informational purposes: MAG100T-VA (09/10) - Master Policy; MAG200T (10/10) - Master Certificate of Insurance; MAG123T (09/10) - Policyholder Application; MAG128T (09/10) - Blank Amendatory Endorsement.

SERFF Tracking Number:	*MRKC-126858975*	*State:*	*Arkansas*
Filing Company:	*Markel Insurance Company*	*State Tracking Number:*	*47696*
Company Tracking Number:	*MAG300T-AR (01/11)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Markel Basic Health Insurance*		
Project Name/Number:	*Markel Basic Health Insurance/MAG300T-AR (01/11)*		

Product description: Group limited benefit health.

This product is for groups and individuals that participate in the Accident & Health trust of Markel Insurance Company.

Please note that the non-trust version of this product was approved by your department. We do not wish to withdraw these forms. This filing represents the forms to be used with our discretionary trust. A copy of the 2005 approval of the non-trust forms is attached to the supporting documentation tab for your reference only.

Company and Contact

Filing Contact Information

Katie Savino,	kjohnston@markelcorp.com
4600 Cox Road	804-527-2700 [Phone] 7701 [Ext]
Glen Allen, VA 23060	804-527-7915 [FAX]

Filing Company Information

Markel Insurance Company	CoCode: 38970	State of Domicile: Illinois
4600 Cox Road	Group Code: 785	Company Type: Property & Casualty
Glen Allen, VA 23060	Group Name:	State ID Number:
(800) 431-1270 ext. [Phone]	FEIN Number: 36-3101262	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	Yes
Fee Explanation:	$50 per form
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Markel Insurance Company	$50.00	01/13/2011	43746375

SERFF Tracking Number:	*MRKC-126858975*	*State:*	*Arkansas*
Filing Company:	*Markel Insurance Company*	*State Tracking Number:*	*47696*
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Product Name:	*Markel Basic Health Insurance*		
Project Name/Number:	*Markel Basic Health Insurance/MAG300T-AR (01/11)*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/08/2011	02/08/2011
Approved-Closed	Rosalind Minor	01/14/2011	01/14/2011

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Forms for Informational Purposes	Katie Savino	02/07/2011	02/07/2011

SERFF Tracking Number:	*MRKC-126858975*	*State:*	*Arkansas*
Filing Company:	*Markel Insurance Company*	*State Tracking Number:*	*47696*
Company Tracking Number:	*MAG300T-AR (01/11)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Markel Basic Health Insurance*		
Project Name/Number:	*Markel Basic Health Insurance/MAG300T-AR (01/11)*		

Disposition

Disposition Date: 02/08/2011
Implementation Date:
Status: Approved-Closed
HHS Status: HHS Approved
State Review: Not Reviewed
Comment:

This submission was re-opened in order for you to make minor changes to the forms that were submitted for informational purposes.

Form MAG 300T-AR (01/11) will remain approved effective 1/14/11.

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MRKC-126858975*	*State:*	*Arkansas*
Filing Company:	*Markel Insurance Company*	*State Tracking Number:*	*47696*
Company Tracking Number:	*MAG300T-AR (01/11)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Markel Basic Health Insurance*		
Project Name/Number:	*Markel Basic Health Insurance/MAG300T-AR (01/11)*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document *(revised)*	Forms for Informational Purposes	Approved-Closed	Yes
Supporting Document	Forms for Informational Purposes	Filed-Closed	Yes
Form	Arkansas Amendatory Endorsement	Approved-Closed	Yes

SERFF Tracking Number:	*MRKC-126858975*	*State:*	*Arkansas*
Filing Company:	*Markel Insurance Company*	*State Tracking Number:*	*47696*
Company Tracking Number:	*MAG300T-AR (01/11)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Markel Basic Health Insurance*		
Project Name/Number:	*Markel Basic Health Insurance/MAG300T-AR (01/11)*		

Disposition

Disposition Date: 01/14/2011
Implementation Date:
Status: Approved-Closed
HHS Status: HHS Approved
State Review:
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MRKC-126858975*	*State:*	*Arkansas*
Filing Company:	*Markel Insurance Company*	*State Tracking Number:*	*47696*
Company Tracking Number:	*MAG300T-AR (01/11)*		
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Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document *(revised)*	Forms for Informational Purposes	Approved-Closed	Yes
Supporting Document	Forms for Informational Purposes	Filed-Closed	Yes
Form	Arkansas Amendatory Endorsement	Approved-Closed	Yes

SERFF Tracking Number:	*MRKC-126858975*	*State:*	*Arkansas*
Filing Company:	*Markel Insurance Company*	*State Tracking Number:*	*47696*
Company Tracking Number:	*MAG300T-AR (01/11)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Markel Basic Health Insurance*		
Project Name/Number:	*Markel Basic Health Insurance/MAG300T-AR (01/11)*		

Amendment Letter

Submitted Date: 02/07/2011

Comments:

Since the date this filing was approved we have had to make amendments to 2 of the VA policy forms that were submitted to you for informational purposes. The changes were to incorporate the FL language within the certificate (for FL residents only) and a few other minor changes were made to the MAG100T-VA (09/10) and the MAG200T-VA (09/10). These changes are shown in the attached amendment.

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Forms for Informational Purposes

Comment:

MAG128T-VA 09-10.pdf

MAG100T 020111.pdf

MAG123T-VA 09-10 FINAL.pdf

MAG200T-VA final 020111.pdf

Approval 020711.pdf

SERFF Tracking Number:	*MRKC-126858975*	*State:*	*Arkansas*
Filing Company:	*Markel Insurance Company*	*State Tracking Number:*	*47696*
Company Tracking Number:	*MAG300T-AR (01/11)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Markel Basic Health Insurance*		
Project Name/Number:	*Markel Basic Health Insurance/MAG300T-AR (01/11)*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 01/14/2011	MAG300T-AR (01/11)	Certificate Amendment, Insert Page, Endorsement or Rider	Arkansas Amendatory Endorsement	Initial		40.700	MAG300TAR0111.pdf

Underwritten By
MARKEL INSURANCE COMPANY
[Deerfield, IL 60015

(referred to as "we", "our" and "us")

LIMITED BENEFIT INSURANCE

ARKANSAS AMENDATORY ENDORSEMENT

This certificate is amended to include the following requirements for residents of Arkansas to the extent provided below:

In Section 8.0 Definitions, the definition of “Emergency” is deleted and replaced with the following:

“Emergency” means care rendered in a hospital emergency facility to evaluate and treat medical conditions of a recent onset and severity, including, but not limited to severe pain, that would lead a prudent person to believe his condition, sickness or injury is of such nature that failure to get immediate medical care places the patient’s health in serious jeopardy or causes serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Under Section 2.0 Effective Date and Termination, the second paragraph of the Effective date for Dependent benefits provision is deleted and replaced as follows:

A newborn child will be Covered from birth for 90 days, including routine nursery charges for the lesser of 5 days in the Hospital nursery following birth or the date of the mother’s discharge. Within the 90 days following the child’s birth, You must notify us, in writing, of the child’s birth and pay any required premium in order to continue coverage after the initial 90 days. Upon receiving notice of birth, We will send You a notice of any additional premium due and indicate when payment is due. Otherwise, the newborn child is considered a late enrollee and may not be enrolled in this Plan until the next open enrollment period established by Us.

Under Section 2.0 Effective Date and Termination, the following is added to the Effective date for Dependent benefits provision:

A child placed in Your custody for whom a petition for adoption has been filed will be Covered beginning on the date of the petition provided You notify Us, in writing, within 60 days of the petition’s date. A newborn child placed in Your custody for whom a petition for adoption has been filed will be Covered from the moment of birth provided You notify us, in writing, within 60 days of the child’s birth. Upon receiving notice of birth or petition for adoption, We will send You a notice of any additional premium due and indicate when payment is due. Otherwise, the adopted child is considered a late enrollee and may not be enrolled in this Plan until the next enrollment period established by Us.

Under Section 3.0 Effective Date and Termination, the Exception for handicapped child provision is revised to delete the 31 days requirement and submitting of proof each year.

In Section 2.0 Effective Date and Termination, The following continuation provision is added:

Continuation. You may continue coverage for yourself [and Your Covered Dependents] if Coverage ended because of termination of [membership/employment/Master Policy] or a change in marital status provided:

- You were Covered under the Plan for 3 continuous months before Coverage ended;
- You elect to continue Your coverage within 31 days after it ends;
- You pay to Your Sponsor in advance on a monthly basis the full cost for Your coverage; and
- You do not become covered under any other plan providing hospital, surgical or medical benefits.

Continuation benefits will not include benefits available under the Dental Care or Vision Care provisions of the Plan, if any.

The coverage will continue until:

- the coverage under this Plan is cancelled;
- the last day of the month for which full premium has been paid; or
- 120 days have elapsed, whichever occurs first.

In section 4.0 Description of Benefits, the following Child Wellness Care provision is applicable and replaces any such provision in the Certificate:

Subject to the terms and conditions of the Plan, We will pay a child wellness care benefit for a Dependent child for Well Child Care at a minimum of 20 visits from the moment of birth through Age 18 years. Child wellness benefits will be limited to one Doctor's visit at approximately the following specified Age intervals:

- birth,
- 2 weeks,
- 2 months,
- 4 months,
- 6 months,
- 9 months,
- 12 months,
- 15 months,
- 18 months,

- 2 years,
- 3 years,
- 4 years,
- 5 years,
- 6 years,
- 8 years,
- 10 years,
- 12 years,
- 14 years,
- 16 years,
- 18 years.

"Well Child Care" means the periodic review of a child's physical and emotional status. Well Child Care will only be Covered to the extent that the services are provided by, or under the supervision of, a single Doctor during the course of one visit. Well Child Care may include the following:

- patient history;
- complete physical examination;
- developmental assessment;
- anticipatory guidance;
- appropriate immunizations;
- laboratory tests; and
- hearing and vision screening in keeping with prevailing medical standards.

The child wellness care benefit payable will be equal to the then current Arkansas Medicaid reimbursement level for the services provided.

The effective date is the covered person's effective date unless specified otherwise.

This rider does not alter or affect any term, provision or condition of the certificate except as expressly stated in this rider.

Executed at Glen Allen, Virginia

MARKEL INSURANCE COMPANY

President

Secretary

SERFF Tracking Number:	*MRKC-126858975*	*State:*	*Arkansas*
Filing Company:	*Markel Insurance Company*	*State Tracking Number:*	*47696*
Company Tracking Number:	*MAG300T-AR (01/11)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Markel Basic Health Insurance*		
Project Name/Number:	*Markel Basic Health Insurance/MAG300T-AR (01/11)*		

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MRKC-126858975*	*State:*	*Arkansas*
Filing Company:	*Markel Insurance Company*	*State Tracking Number:*	*47696*
Company Tracking Number:	*MAG300T-AR (01/11)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Markel Basic Health Insurance*		
Project Name/Number:	*Markel Basic Health Insurance/MAG300T-AR (01/11)*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	01/14/2011

Comments:

Attachment:

AR Flesch Certification.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	01/14/2011

Comments:

Attachment:

MAG123T-VA 09-10 FINAL.pdf

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	01/14/2011
Bypass Reason:	N/A- Not individual		

Comments:

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	01/14/2011
Bypass Reason:	N/A- Not Major Medical		

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter	Approved-Closed	01/14/2011

Comments:

Attachment:

SERFF Tracking Number:	*MRKC-126858975*	*State:*	*Arkansas*
Filing Company:	*Markel Insurance Company*	*State Tracking Number:*	*47696*
Company Tracking Number:	*MAG300T-AR (01/11)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Markel Basic Health Insurance*		
Project Name/Number:	*Markel Basic Health Insurance/MAG300T-AR (01/11)*		

Cover letter 011111.pdf

		Item Status:	**Status Date:**
Satisfied - Item:	Forms for Informational Purposes	Approved-Closed	02/08/2011

Comments:

Attachments:

MAG128T-VA 09-10.pdf
MAG100T 020111.pdf
MAG123T-VA 09-10 FINAL.pdf
MAG200T-VA final 020111.pdf
Approval 020711.pdf

MARKEL INSURANCE COMPANY

4600 Cox Road Glen Allen, Virginia 23060-9817 P.O. Box 3870, Glen Allen, Virginia 23058-3870
(804) 527-2700 (800) 431-1270 Fax (804) 527-7915

FLESCH READABILITY CERTIFICATION

The form listed below meets the minimum reading score established by the State of Arkansas statute 23-80-207.

FORM NUMBER	FLESCH SCORE
MAG300T-AR (01/11)	40.7

_____ 1/11/11

Mark Nichols Date
Vice President
Markel Insurance Company

MARKEL INSURANCE COMPANY

Participating Entity Application for Group Limited Benefit Insurance

Participating Entity's Legal Name: [ABC Group] Alternative Name – DBA:	Federal Tax ID Number: [123456789]
Address:[123 Street]	Contact Person: [John Doe]
City, State & Zip Code:[Anywhere, USA 12345]	Phone: [(123) 456-7890] Fax: [(123) 456-7891] Email: [JohnDoe@ABCGroup.com]
Principal Industry: [Food Service] SIC Code	
Location Name (if different from above):	Contact Person:
Mailing Address (if different from above):	Phone: Fax:
City, State & Zip:	Email:

Participating Entity Contribution:

☐ **Contributory—Indicate amount ($ or %)** _____ ☐ **Voluntary**

☐ **Blanket**

Requested Effective Date:	**Rating Method:**	**Billing Mode:**	**Total Number of:**
_____ mm/dd/yy	☐ Monthly	☐ Monthly	Eligible Applicants: _____
Annual Open Enrollment Month:		☐ Quarterly	Participating Applicants*: _____
_____ mm/dd/yy			

Describe Classes of Eligible Employees to Include (if employer group):

Class 1: Full Time employees:
Waiting Period: ☐ No ☐ Yes (if yes, indicate time period below)

Initial Enrollment: _____ Days

New Participants: _____ Days

Describe Classes of Eligible Employees to Include (if employer group):

Class 2: Part Time employees:
Waiting Period: ☐ No ☐ Yes (if yes, indicate time period below)

Initial Enrollment: _____ Days

New Participants: _____ Days

Check One:

☐ This request is for NEW INSURANCE COVERAGE

☐ This request is for INSURANCE TO REPLACE THE FOLLOWING:

Name of Carrier	Coverage(s)	Plan or Policy No.(s)	Date(s) of Replacement

Request for Acceptance as Participating Entity

(1) The Participating Entity requests coverage for its participants, as indicated, under the Master Policy of insurance made available. The Participating Entity also agrees to be bound by all of the terms, conditions and limitations of the Master Policy. The Participating Entity further understands and agrees that:
   a) This request shall not cause insurance coverage to become effective on any person. In order for coverage to take effect on the date specified by Markel Insurance Company: (i) the Participating Entity must be accepted; and (ii) each person must satisfy the eligibility requirements of the Master Policy.
   b) In the event that (i) the Participating Entity normally remits premium on behalf of its participants, and (ii) one or more participants is not actively at work but is eligible for continuation of coverage, the Participating Entity must continue to remit the applicable premiums for such participants in order for them to maintain coverage. In such instances, it may be necessary for the Participating Entity to collect premiums from these participants.

(2) Acceptance of this request is subject:
   a) to all of Markel Insurance Company's requirements; and
   b) to all of the terms of the Group Master Policy issued.

(3) Markel Insurance Company will notify the Participating Entity of any approval or disapproval of this request. Any notice of approval will specify the Participating Entity's plan or plan change effective date. For participants, Markel will issue certificates of insurance summarizing the provisions of the Group Plan principally affecting the insurance.

(4) **This plan is not intended to replace comprehensive Major Medical Insurance.**

Fraud Warning: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

X_____ _____ X_____
Signature of Participating Entity's Authorized Representative Date

X_____ X_____
Agent/Broker Signature Title

AGENT/BROKER

NAME: _____ COMPANY NAME: _____

ADDRESS: (Street, City, State, Zip Code)

_____

PHONE NUMBER: FAX NUMBER: LICENSE ID NUMBER: TAX ID NUMBER:

_____

TRUSTEE

The Applicant hereby makes application for Master Policy Number [0123456] on behalf of their eligible members.

Signed at [City, State], this [date] day of [month], [year].

Application made by: _____, trustee. Title: _____

On behalf of: [ABC Trust]
Whose address is: [Street]; [City,] [State] [Zip Code]

Witness: _____ Title: _____

All administrative correspondence and inquiries should be directed to:
Markel Insurance Company
[Accident & Health Department]
[P.O. Box 3870,] [Glen Allen,] [VA] [23058]
[Telephone: 800-431-1270]

MARKEL INSURANCE COMPANY

4600 Cox Road Glen Allen, Virginia 23060-9817 P.O. Box 3870, Glen Allen, Virginia 23058-3870
(804) 527-2700 (800) 431-1270 Fax (804) 527-7915

January 11, 2011

Arkansas Insurance Department
Life & Health Division
1200 West Third Street
Little Rock, AR 72201

Re: Markel Insurance Company
NAIC #38970
Group Limited Benefit Health – Large and Small Group
Discretionary Group Trust Filing

Enclosure: MAG300T-AR (01/11) Arkansas Amendatory Endorsement

Dear Commissioner:

The above referenced form is submitted for your review and approval. We have also submitted the Master Policy, Certificate, Application and Blank Amendatory Endorsement for this Trust product that was approved in the trust's domicile state of Virginia on November 9, 2010. This form is new and does not replace any forms previously approved by your Department.

This product is for groups and individuals that participate in the Accident & Health trust of Markel Insurance Company. The forms have been approved in the situs state, Virginia.

Please note that the non-trust version of this product was approved by your department on December 18, 2000. This filing represents the forms to be used with our discretionary group trust.

We trust that we have satisfactorily complied with all your requirements. We look forward to your stamp of approval and the opportunity to offer this product to the residents of Arkansas. If you have any questions regarding this filing, please call or email me at the address below.

Thank you for your attention and consideration.

Sincerely,

Katie J Savino

Katie Savino
Regulatory Compliance Specialist, Markel Accident & Health Division
Tel. (800) 431-1270 Extension 7701
E-mail: ksavino@markelcorp.com

MARKEL INSURANCE COMPANY

Group Limited Benefit Health [Master Policy] [Certificate of Insurance]

Master Policy No: [012345]
[Participating Entity Policy No: [12345]]
Rider No: [1]

This [Master Policy] [Certificate of Insurance] is amended to include the following requirements to the extent provided below:

[AMEND: MAG100T-VA; Master Policyholder's Address:
The Master Policyholder's address is changed to: 123 Main Street; Anywhere, USA 12345.**]**

[AMEND: MAG100T-VA; Cancellation By The Company/Participating Entity:
In addition, We may cancel a Participating Entity's coverage when the number of covered persons is less than [4 -1,000] [[or] [10-99%] of the number of eligible individuals of the Participating Entity.**]**

[AMEND: MAG200T-VA; SCHEDULE OF BENEFITS
[Premium Due Date: [1st- 31st] of each [week] [month]]

[AS REQUESTED BY THE PARTICIPATING ENTITY, EFFECTIVE [Month/Date/Year], THE FOLLOWING IS AMENDED: MAG200T-VA; SCHEDULE OF BENEFITS:
[**Doctor's Office Visits**: [$30 - $125] per visit to a Doctor's office or outpatient facility
Maximum Benefit: [1-25] visit(s) per Covered Person per Calendar Year]**]**

This rider does not alter or affect any term, provision or condition of the [Master Policy] [Certificate of Insurance] except as expressly stated in this rider.

MARKEL INSURANCE COMPANY

[Deerfield, Illinois 60015]

"the Company"

LIMITED BENEFIT INSURANCE

[MASTER] POLICY

Policy Number:	[0123456]
Policyholder:	[ABC Trust, ABC Association, XYZ Company]
Policy delivered in and governed by the laws of:	[State]
Effective date of the Policy:	[Month, Day, Year, Perpetual]
Expiration date of the Policy:	[Month, Day, Year]

This Policy contains the terms under which the Company agrees to insure certain individuals and pay benefits. The consideration for this contract is the application of the Policyholder and the payment of the premiums. The Company and the Policyholder have agreed to all of its terms.

Executed at [Glen Allen, Virginia]

[ ] President

[ ] Secretary

Notice to Buyer: This is a Limited Benefit policy. This is not designed to be a comprehensive medical or major medical policy. The benefits provided by this insurance are limited, and may not cover all medical expenses. You may have to pay substantial amounts of your own money for medical expenses, even if your illness is serious. Your benefit is limited to a specific dollar amount and number of days. Please read your Schedule of Benefits carefully.

TABLE OF CONTENTS

EXHIBITS - The following list of Exhibits identifies the insurance certificate(s) and any other documents which is/are incorporated and made a part of this Policy:

A APPLICATION

B CERTIFICATE OF INSURANCE

C POLICY RIDER

SECTION 1.0 PARTICIPATION

Policyholder(s). Upon application and acceptance by Us, the Policyholder may purchase or endorse the purchase of insurance coverage(s) provided by this Policy for their eligible individuals.

Eligible Classes. The classes of individuals eligible for insurance are defined in the application. Only individuals who are part of an eligible class can be insured.

Waiting Period. The "Waiting Period" is a continuous period of time (as defined in the applicable certificate(s) of insurance) before application can be made for insurance during which an eligible individual must be associated with a Policyholder.

Eligibility For Insurance. Each individual in a class of eligible individuals will become eligible to apply for insurance on the date he completes the required Waiting Period (if any).

Premium Contribution. With Our approval, the Policyholder(s) may require contributions to the premium by eligible individuals who become insured under this Policy.

[**Effective Date.** A Policyholder's effective date will be the later of the following:
- the Policy's effective date; or
- the first day of the month coinciding with or next following the date that the Policyholder's application has been approved by Us or the date shown on the Policyholder's application.]

SECTION 2.0 CANCELLATION

Cancellation By The Policyholder. The Policyholder may cancel this Policy as of any premium due date by giving Us at least [31] days prior written notice.

Cancellation For Non-Payment of Premium. If any premium due from the Policyholder is not paid when due or within the Grace Period, the Policy will automatically cancel at the end of the Grace Period.

Cancellation By The Company. We may cancel this Policy for any reason after the first insurance year by giving the Policyholder at least [31] days prior written notice.

[**Cancellation of a Trust Participation**. Participation of the Policyholder's coverage under the Trust will end on the first to occur of the following:

- the date this Policy is cancelled; or
- the last day for which the Policyholder has made the required contributions for the insurance; or
- the date the Policyholder ceases to participate in this Policy; or
- the date elected by the Policyholder provided that prior written notice has been provided to Us; or
- the premium due date after We have provided at least 31 days written notice of termination to any Policyholder; or
- the date further participation by the Policyholder would, in Our opinion, violate the provisions of any state or federal law, regulation or government ruling.

We may cancel the participation of a Policyholder on the last day of the insurance month in which the number of Covered Persons is less than [2-100] [or] [10-99%] of the number of eligible individuals of the Policyholder.]

SECTION 3.0 PREMIUMS

Initial Premium Rates. We have set the initial premium rates.

Premium Payments. Unless otherwise agreed by Us, premiums are payable monthly in advance. For non-contributory coverage, the first premium is due on the effective date of the Policy. Subsequently, premiums are due on the first day of each insurance month. We may, however, agree to less frequent intervals. All premiums are payable at Our Home Office in [Glen Allen, Virginia] or Our designated agent or administrator.

Premium Calculation and Adjustment. The premium due for each month, or other agreed modal period, will be the sum of the amounts for each of the benefits provided in the Policy.

Changes in Premium Rates. Premium rates and any tables used in the calculation of premium may be changed by Us from time to time on written notice to the Policyholder at least [31] days before the date the change is to be effective.

Premium rates may not be changed in the first insurance year unless:

- the terms of the insurance coverage are changed, either by agreement among the parties or by law or regulatory requirement;
- the nature of the risk changes materially.

If a change takes place other than on a premium due date, a pro rata premium for the period from the date the change takes place to the next premium due date will be calculated and due on the date the change takes effect, subject to the provisions of the grace period.

Grace Period. This Policy has a 31 day grace period. If the premium is not paid by the due date, it may be paid during the 31 days immediately following the due date. During the "grace period" coverage shall continue in force unless You give Us written notice of discontinuance in accordance with the terms of the policy and in advance of the date of discontinuance. The Policy will remain in force during the grace period. All premiums must be paid for Insurance in force during the grace period. The grace period does not apply:

- to the first premium due date; or
- to premiums due thereafter if We have given [31-365] days' prior notice to the Policyholder that We will not renew the Policy.

SECTION 4.0 GENERAL PROVISIONS

Entire Contract; Changes. This Policy, Certificate, Endorsements and any application including any attached exhibits and application of the Policyholder constitute the entire contract. Any change, modification or waiver of this Policy or a certificate issued under it must be in writing and signed by one

of the following: Our President; Our Vice-President; a Secretary; or Assistant Secretary. A copy of any application shall be attached to the policy, all statements made by You shall be deemed representations not warranties, and no written statement made by any person shall be used in any contest unless a copy of the statement is furnished to the person or to his beneficiary or personal representative.

Statements Not Warranties. In the absence of fraud, all statements made in any application for this insurance are considered representations and not warranties. No such statement will be used to avoid or reduce the insurance unless it is contained in a written, signed statement. If the statement is made by a Covered Person, We must furnish a copy to the Covered Person or his beneficiary, if applicable.

Incontestability. We will not contest the validity of this Policy after it has been in force for two years from its effective date. No statement made by a Covered Person will be used to contest the validity of any insurance after it has been in force for two years unless the statement is contained in a written instrument signed by a Covered Person; except for non-payment of premiums exclusive of any period(s) the person was totally disabled.

Information Required. The Policyholder will provide, or cause to be provided, all the data We need to calculate the premiums and all other data We may reasonably require. The Policyholder, or their designated agent, will provide to Us by the 10th day of each month, or at such other time as may be agreed by Us, information about changes with respect to each Covered Person's insurance status, including, but not limited to: (i) the addition of new Covered Persons; (ii) the termination of Covered Persons, or (iii) notice that there are no changes which would affect any Covered Person's eligibility under the Policy.

Clerical error in the provided information will not:

- invalidate a Covered Person's insurance;
- delay a change in a Covered Person's insurance; or
- maintain a Covered Person's insurance beyond the date it would have ceased had the correct information been furnished.

Upon discovery of a clerical error, We will correct the records and adjust the premium on the basis of the correct information. However, premium refunds are limited to premiums paid during the then current insurance year but not to exceed three months.

We will not be considered an agent of the Policyholder for any purpose. The Policyholder will not be considered Our agent for any purpose.

Examination and Audit. At any reasonable time and for any purpose relating to this Policy, the Policyholder's records shall be open for Our inspection and audit. Such examination may be made during the Policy term; within 3 years after the Policy is terminated; or until final settlement of all claims hereunder, whichever is later.

Misstatement of Age. If the age of an individual is misstated, upon discovery of the true facts, the records will be corrected and the premiums adjusted. Premium refunds are limited to premiums paid during the then current insurance year but not to exceed three months.

Certificate. We will furnish a certificate of insurance for each Covered Person [or family]. The certificate will govern:

- benefit amounts, maximums, limits and other information contained in its schedule;
- information as to whom benefits are payable;
- the benefit plan provisions;
- certain participation rules and requirements; and
- any exclusions, reductions and limitations.

MARKEL INSURANCE COMPANY

Participating Entity Application for Group Limited Benefit Insurance

Participating Entity's Legal Name: [ABC Group] Alternative Name – DBA:	Federal Tax ID Number: [123456789]
Address:[123 Street]	Contact Person: [John Doe]
City, State & Zip Code:[Anywhere, USA 12345]	Phone: [(123) 456-7890] Fax: [(123) 456-7891] Email: [JohnDoe@ABCGroup.com]
Principal Industry: [Food Service] SIC Code	
Location Name (if different from above):	Contact Person:
Mailing Address (if different from above):	Phone: Fax:
City, State & Zip:	Email:

Participating Entity Contribution:

☐ **Contributory—Indicate amount ($ or %)** _____ ☐ **Voluntary**

☐ **Blanket**

Requested Effective Date:	**Rating Method:**	**Billing Mode:**	**Total Number of:**
_____ mm/dd/yy	☐ Monthly	☐ Monthly	Eligible Applicants: _____
Annual Open Enrollment Month:		☐ Quarterly	Participating Applicants*: _____
_____ mm/dd/yy			

Describe Classes of Eligible Employees to Include (if employer group):

Class 1: Full Time employees:
Waiting Period: ☐ No ☐ Yes (if yes, indicate time period below)

Initial Enrollment: _____ Days

New Participants: _____ Days

Describe Classes of Eligible Employees to Include (if employer group):

Class 2: Part Time employees:
Waiting Period: ☐ No ☐ Yes (if yes, indicate time period below)

Initial Enrollment: _____ Days

New Participants: _____ Days

Check One:

☐ This request is for NEW INSURANCE COVERAGE

☐ This request is for INSURANCE TO REPLACE THE FOLLOWING:

Name of Carrier	Coverage(s)	Plan or Policy No.(s)	Date(s) of Replacement

Request for Acceptance as Participating Entity

(1) The Participating Entity requests coverage for its participants, as indicated, under the Master Policy of insurance made available. The Participating Entity also agrees to be bound by all of the terms, conditions and limitations of the Master Policy. The Participating Entity further understands and agrees that:
   a) This request shall not cause insurance coverage to become effective on any person. In order for coverage to take effect on the date specified by Markel Insurance Company: (i) the Participating Entity must be accepted; and (ii) each person must satisfy the eligibility requirements of the Master Policy.
   b) In the event that (i) the Participating Entity normally remits premium on behalf of its participants, and (ii) one or more participants is not actively at work but is eligible for continuation of coverage, the Participating Entity must continue to remit the applicable premiums for such participants in order for them to maintain coverage. In such instances, it may be necessary for the Participating Entity to collect premiums from these participants.

(2) Acceptance of this request is subject:
   a) to all of Markel Insurance Company's requirements; and
   b) to all of the terms of the Group Master Policy issued.

(3) Markel Insurance Company will notify the Participating Entity of any approval or disapproval of this request. Any notice of approval will specify the Participating Entity's plan or plan change effective date. For participants, Markel will issue certificates of insurance summarizing the provisions of the Group Plan principally affecting the insurance.

(4) **This plan is not intended to replace comprehensive Major Medical Insurance.**

Fraud Warning: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

X_____ _____ X_____
Signature of Participating Entity's Authorized Representative Date

X_____ X_____
Agent/Broker Signature Title

AGENT/BROKER

NAME: _____ COMPANY NAME: _____

ADDRESS: (Street, City, State, Zip Code)

_____

PHONE NUMBER: FAX NUMBER: LICENSE ID NUMBER: TAX ID NUMBER:

_____

TRUSTEE

The Applicant hereby makes application for Master Policy Number [0123456] on behalf of their eligible members.

Signed at [City, State], this [date] day of [month], [year].

Application made by: _____, trustee. Title: _____

On behalf of: [ABC Trust]
Whose address is: [Street]; [City,] [State] [Zip Code]

Witness: _____ Title: _____

All administrative correspondence and inquiries should be directed to:
Markel Insurance Company
[Accident & Health Department]
[P.O. Box 3870,] [Glen Allen,] [VA] [23058]
[Telephone: 800-431-1270]

Underwritten By
MARKEL INSURANCE COMPANY
[Deerfield, IL 60015]

(referred to as "we", "our" and "us")

LIMITED BENEFIT INSURANCE

CERTIFICATE OF INSURANCE

This booklet summarizes the benefits and limitations provided under the Insurance Plan.

A few words about this document - We have written it in plain English. A few terms and provisions are written as required by insurance law. It is part of a Master Policy. Please read it carefully. Any questions about the terms or provisions, please contact Us or our administrator.

[ ] President

[ ] Secretary

Markel Insurance Company
[4600 Cox Road, Glen Allen, VA 23060]

This Coverage may be terminated or modified in whole or in part under the terms and provisions of the Master Policy.

IMPORTANT INFORMATION REGARDING THIS INSURANCE

Notice to Buyer: This is a Limited Benefit policy. This is not designed to be a comprehensive medical or major medical policy. The benefits provided by this insurance are limited, and may not cover all Your medical expenses. You may have to pay substantial amounts of Your own money for medical expenses, even if Your illness is serious. Your benefit is limited to a specific dollar amount and number of days. Please read Your Schedule of Benefits carefully.

[For FL Residents: THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED PRIMARILY BY THE LAW OF A STATE OTHER THAN FLORIDA]

31-Day Free Examination Period. Please examine Your certificate. Within 31 days after delivery, You can return it to the Administrator with Your written request for a refund of all premiums paid. When so requested, the certificate will be null and void from its inception.

In the event you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in the sale of this insurance or if you have additional questions you may contact the insurance company issuing this insurance at the following address and telephone number: Markel Insurance Company; [4600 Cox Road, Glen Allen, VA 23060;] [Toll Free: 1-800-431-1270.] If you have been unable to contact or obtain satisfaction from the Company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at: [P.O. Box 1157, Richmond, VA 23218]; Toll free nationwide: [877-310-6560] or Toll free Virginia residents: [800-552-7945]. Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, Company or the Bureau of Insurance, have your policy number available.

SCHEDULE OF BENEFITS

Master Policyholder: [ABC Bank, as trustee]
Master Policy Number: [0123456]

Insured's Name: [John Doe]
Insured's Certificate Number: [987654321]

Policy Anniversary: [None]
Effective Date: [September 1, 2010]
Transfer of Coverage: [Applicable] [Not Applicable]

Premium Due Date: [1st - 31st] of each [week] [month] [quarter] [annual],
[Waiting Period: [[0-90] days**/[For FL Residents: Hours of Work Credit Per Month]]**

PLAN BENEFITS

[**Hospital Income**: [$50 - $2,000] for the [1st – 10th] day(s) [and [$50 - $2,000] for subsequent days]
Maximum Benefit – [10 – 500] days per Confinement

[Optional Benefits:
[Convalescent Facility [Included/Not Included]
[ICU/CCU [Included/Not Included]
[Heart Attack/Stroke/Cancer [Included/Not Included]
[Mental Illness/Alcohol or Drug Abuse [Included/Not Included]

[**First Hospital Confinement**: [$50 - $5,000] for the first Hospital Confinement per Covered Person per Calendar Year]

Days of First Hospital Confinement	**Benefit Amount**
[1]	[$50 - $5,000]
[2]	[$50 - $5,000]
[3]	[$50 - $5,000]
[4]	[$50 - $5,000]
[5]	[$50 - $5,000]
[6]	[$50 - $5,000]
[7]	[$50 - $5,000]
[8]	[$50 - $5,000]
[9]	[$50 - $5,000]
[10]	[$50 - $5,000]

This is not cumulative benefit and will not exceed [$50 - $5,000]. The amount payable corresponds to the number of days Confined to a Hospital for the first Hospital Confinement per Covered Person per Calendar Year.]

[**Doctor's Office Visits**:	[$30 - $125] per visit to a Doctor's office or outpatient facility Maximum Benefit: [1-25] visit(s) per Covered Person per Calendar Year]
[**Doctor's Office Visit For Wellness Care**:	[$30 - $125] per visit Maximum Benefit: [1-5] visit(s) per Covered Person per Calendar Year]
[**Child Wellness Care**:	[$30 - $125] per visit]
[**Diagnostic Testing and X-ray**:	[$30 - $125] per visit to a Doctor's office or outpatient facility Maximum Benefit: [1-10] visit(s) per Covered Person per Calendar Year]
[**Surgery**:	[$250 -$2,000] for [1-10] Inpatient Hospital surgery per Covered Person per Calendar Year [$100 - $2,000] for [1-10] outpatient surgery performed in a Hospital or outpatient surgery center per Covered Person per Calendar Year]
[**Emergency Room**:	[[$25 -$500] for [1-10] visit(s) to the emergency room when not Hospital confined for Injury per Covered Person per Calendar Year] [[$25 -$500] for [1-10] visit(s) to the emergency room when not Hospital confined for Sickness per Covered Person per Calendar Year] [[$25 -$500] for [1-10] visit(s) to the emergency room when not Hospital confined for Injury and Sickness per Covered Person per Calendar Year]]
[**Ambulance**:	[$25 - $500] per trip and [1 - 3] trip(s) per Covered Person per Calendar Year]
[**Vision Care**:	[$30-$75] towards one eye exam by a Doctor per Covered Person per Calendar Year [$30 -$200] towards a pair of frames and lenses or a pair of contact lenses per two consecutive per Calendar Years]
[**Disability Income**:	Benefit Waiting Period: [0-365] consecutive days Disability Income Benefit Amount: [50-75%] of Basic Salary to maximum of [$50 -$1,000] per week Maximum Benefit Period: [1-104] week(s) Applicable to the person only]
[**Dental Care**:	The Benefit Amount shown in the following table will be paid for each Covered Dental Expense subject to the following Maximum Benefits: [$500 -$4,000] for Covered Dental Expenses per Covered Person per Calendar Year

[$500 -$2,500] for periodontal treatment per Covered Person while Covered under the Plan and subject to the Calendar Year maximum

[[$500 -$1,500] for Comprehensive Orthodontic Treatment per Covered Person while Covered under the Plan and not subject to the Calendar Year maximum]

[**Dental Plan**]

Benefit Category		**Benefit Amount**
Type 1: Preventive &		
Diagnostic Care	Oral Exam, including prophylaxis	[$ 48.00]
	X-rays, bitewings per film	[$ 6.40]
	X-rays, panoramic or full mouth	[$ 48.00]
	[Sealants, topical fluoride]	[$ 13.60]
	Space maintainers	[$144.00]
Type 2: Major Restorative		
	Crowns, inlays, onlays, bridges (each unit) & dentures	[$240.00]
	Pre-fabricated crowns	[$ 80.00]
	Crown build-up procedures	[$ 64.00]
Type 3: Minor Restorative		
	Fillings	[$ 56.00]
	Crown, bridge and denture repairs; tissue conditioning	[$ 32.00]
	Relining or rebasing dentures	[$ 80.00]
Type 4: Endodontics		
	Root canals, apicoectomies	[$256.00]
	Root amputation	[$128.00]
	Therapeutic pulpotomy, retrograde fillings, apexification, hemisection	[$ 64.00]
Type 5: Periodontics		
	Tissue grafts; osseous surgery (per quadrant)	[$128.00]
	Gingivectomy (per quadrant), periodontal scaling (per quadrant), periodontal splinting; root planing	[$ 80.00]
	Gingivectomy (per tooth)	[$ 32.00]
	Gingival curettage (per quadrant)	[$ 48.00]

Type 6: Oral Surgery		
	Surgeries Level 1	[$160.00]
	Surgeries Level 2	[$ 88.00]
	Surgeries Level 3	[$ 64.00]
Type 7: Anesthesia		
	IV or first half hour general	[$ 96.00]
	additional quarter hour general	[$ 96.00]
[Type 8: Comprehensive Orthodontic Treatment	Maximum while Covered under the Plan:	[$250.00]]

[[**Accidental Death**] [**& Dismemberment**]:

Principal Sum - [$5,000 -$50,000]
OPTIONAL BENEFITS:
[Family Plan]
[5X Child Accidental Dismemberment]
[Exposure & Disappearance]]

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SECTION 1.0 ELIGIBILITY

Eligibility. You are eligible for Coverage if You meet the following criteria:
- [You are Actively at Work];
- [**N/A For FL Residents:** You are not Disabled];
- [You are at least 18 but not over [60-70] years of age]
- [You have satisfied the Waiting Period indicated on the Schedule of Benefits Page;]
- You are a resident in the United States; and
- You are not in full-time service of the Armed Forces.

[You may elect to cover Your Dependents if they:
- are in a class that qualifies for Dependent benefits;
- are insured under the Plan; and
- have one or more eligible Dependents.

Dependent(s) are eligible for Coverage if they are:
- a resident in the United States;
- not in full-time service of the Armed Forces;
- [at least 18 but not over [60-70] years of age]
- not Covered independently of You under the Plan; and
- engaging in the normal daily activities of a person who is the same Age and gender.

If You or Your spouse [or Domestic Partner] are Covered under the Plan independently of each other, only one of You may elect Coverage for their Dependent children. If any of their Dependents are Covered under the Plan independently, they may not also be Covered as Your Dependent.]

[While receiving disability benefits under this Plan, You are not eligible to apply for increased or new benefits.] [You must sign a form acceptable to Us which gives the Participating Entity permission to withhold such premium from Your pay.]

[No Coverage will become effective, whether a new application or a change in benefits, if You are not Actively at Work on the effective date of Coverage. [No Coverage will become effective for any Dependent, whether a new application or a change in benefits, if such Dependent is not engaging in the usual activities of a person who is the same Age and gender.] Coverage will be deferred until You are Actively at Work [or Your Dependent resumes normal daily activities.]

[**N/A For FL Residents:** No Coverage will become effective, whether a new application or a change in benefits, if You are Disabled on the effective date of Coverage. Coverage will be deferred until You are no longer disabled.]

Enrollment. You must complete an enrollment form giving the information We require [, including information on any Dependents to be Covered]. [If You are required to pay all or part of the premium for this Coverage, You must sign a form acceptable to Us which gives the Participating Entity permission to withhold such premium from Your pay].

You [and Your Dependents] may enroll in this Plan:

- [during the time period established by Us following the Master Policy effective date;]
- [during an open enrollment time period established by Us which allows all eligible persons of the Participating Entity to enroll; or]
- [during the 31 day time period beginning on a person's date of initial eligibility.]

Any person who does not enroll during one of these three times is considered a "late enrollee" and may not enroll until the next open enrollment period established by Us. However, such person is not considered a "late enrollee" if, within 31 days of acquiring a new spouse [or Domestic Partner] or child(ren) by marriage [or Domestic Partnership], birth, adoption or placement for adoption, You request enrollment for [You, Your new spouse [or Domestic Partner] or child(ren)].

Schedule of Benefits. This document describes the benefits for the Coverage(s) shown on the Schedule of Benefits Page that apply to the Covered Persons. You should read the whole document for a complete description of the benefits and of any exclusions, reductions or limitations which may apply.

No Insurance, other than that indicated on the Schedule of Benefits Page applies to the Covered Person even though it may be described or referred to elsewhere in this document. To determine which Coverage applies to the Covered Person, please read carefully the eligibility, effective date and termination sections of this document.

SECTION 2.0 EFFECTIVE DATE AND TERMINATION

Effective date for Your benefits. If You have met the eligibility requirements, Your Coverage will be effective on the [1st-30th] day of the month following the date that We approve Your enrollment in the Plan provided that the first premium has been paid.

[Effective date for Dependent benefits. If Your Dependent(s) have met the eligibility requirements, their Coverage will be effective on the later of:

- the date You become Covered and request Coverage for Your Dependent(s) on their enrollment form; or
- if subsequent to You becoming Covered under the Plan, the [1st-30th] day of the month following the date We approve Your Dependent's Coverage.

A newborn child, adopted child or any child placed in Your custody for adoption will be Covered from birth or placement if You notify Us, in writing, within 31 days of the child's birth or placement and pay any required premium. Upon receiving notice of birth or placement, We will send You a notice of any additional premium due and indicate when payment is due. Otherwise, the newborn child, adopted child or child placed for adoption is considered a late enrollee and may not be

enrolled in this Plan until the next open enrollment period established by Us. Failure to furnish such notice or pay such premium shall not prejudice any claim originating within such 31-day period.]

[Effective date for Initial Eligibility. If You [or Your Dependent(s)] have met the eligibility requirements, applied within the initial eligibility period and are not considered a "late enrollee", Coverage will be effective as follows depending on the event that caused the initial eligibility status:

Event	Effective Date of Coverage
Birth of child, adoption or placement of a child for the purposes of adoption	The date of the event
Marriage [or Domestic Partnership]	The first of the month following the date of marriage [or date of Domestic Partnership]
[Date of Hire	The first of the month following completion of the Waiting Period provided an enrollment form has been completed and submitted to Us]
[Date of Membership	The [first] of the month following the date of membership provided an application has been approved by Us.]

Cancellation of Your Coverage. Your Coverage will end on the first of the following to occur:

- the date the Master Policy is canceled;
- the date you reach the age of [60-70];
- the last day for which the full premium has been paid;
- the last day of the month in which Your [employment] [membership] [participation] with the Participating Entity ends];
- the last day of the month in which You are pensioned or retired;
- the date You no longer meet the Participating Entity's class criteria;
- the date Your Participating Entity ends participation in the Plan; or
- the date You request cancellation of all or a part of their Coverage under the Plan;

[Cancellation of Dependent Coverage. Coverage of Dependent(s) will end on the first of the following to occur:

- the date Your Insurance ends;
- the date your Spouse reaches the age of [60-70];
- the last day for which the full premium has been paid;
- the date We cancel all Dependent Coverage;
- the last day of the month when He no longer meets the definition of a Dependent; [or]
- the date You request cancellation of all or a part of Your Dependent's Coverage[; or]
- [for a Domestic Partner and a Dependent child of a Domestic Partner, the last day of the month when the Domestic Partner no longer meets the definition of Domestic Partner].

Exception for handicapped child. An [**N/A for FL residents:** unmarried] child Covered under this Plan who is chiefly dependent on You for financial support because He is incapable of self-sustaining employment because of mental incapacity or physical handicap will not lose His Coverage because He has reached the limiting Age for a Dependent child if We receive proof of

handicap and support within 31 days of His birthday. The child's Coverage can then be continued until it would otherwise end as described above. After two years have passed, We will require further proof only once a year.]

[For FL Residents: Extension of benefits - Hospital Income. If, while Totally Disabled, coverage terminates for any reason other than the Covered Person's non-payment of premium, coverage for Hospital Income benefits will be continued for that Covered Person for a Hospital Confinement for the Injury or Sickness causing Total Disability. This extension of benefits will continue until the end of 90 days after the date coverage terminated; however no benefits are payable beyond any Maximum Benefit stated on the Certificate Data Page. For the purposes of this provision, "Totally Disabled" or "Total Disability" means that, because of Sickness or Injury, the Covered Person is unable to perform all of the substantive and material duties of his or her occupation. For a Covered Person who is not employed, "Totally Disabled" or "Total Disability" means that, because of Sickness or Injury, he or she cannot perform the normal activities of a person of like age and gender.]

[For FL Residents: Extension of benefits. If, while Totally Disabled, a Covered Person's coverage terminates for any reason other than the Covered Person's non-payment of premium , coverage will remain in effect for benefits for the Injury or Sickness causing Total Disability until he or she is no longer Totally Disabled, the end of 90 days after the date coverage terminated, or all available benefits have been paid under the plan, whichever occurs first. For the purposes of this provision, "Totally Disabled" or "Total Disability" means that, because of Sickness or Injury, the Covered Person is unable to perform all of the substantive and material duties of his or her occupation. For a Covered Person who is not employed, "Totally Disabled" or "Total Disability" means that, because of Sickness or Injury, he or she cannot perform the normal activities of a person of like age and gender.]

[For FL Residents: Extension of benefits for maternity. If, while she is pregnant, a Covered Person's coverage terminates for any reason other the Covered Person's non-payment of premium, coverage will remain in effect for any pregnancy- related benefits until the end of the pregnancy.]

[For FL Residents: Extension of benefits for dental care. If a Covered Person's coverage terminates for any reason other the Covered Person's non-payment of premium or voluntary cancellation, coverage will remain in effect for Dental Care benefits for any course of treatment or dental procedures recommended in writing and commenced, in connection with a specific Injury or Sickness incurred while this Policy was in effect, by the attending Doctor or Dentist while coverage under this Policy was in effect. This extension will not apply to dental care benefits for routine examinations, prophylaxis, x-rays, sealants or orthodontic services. Coverage under this extension of benefits will cease 90 days after the date coverage otherwise terminated or the date such benefits are covered under a succeeding plan, whichever occurs first.]

Effect of Cancellation on Claims. Termination of the Master Policy will not affect any claim which occurs while the Plan is in force. No benefit will be continued beyond the period for which the required premium is paid.

[Continuation of Coverage for Dependents. Benefits for Your Dependent(s) will continue with no premium required, for up to eighteen (18) months after the end of the month in which Your death occurs.]

[Reinstatement of Coverage. If You cease to be eligible for Coverage You may qualify for reinstatement within 90 days from the date You were last eligible. [You will be reinstated and eligible for Coverage on the [1st-30th] day of the calendar month following a month in which You work and satisfy a new Waiting Period].

[If You do not qualify for reinstatement and are re-employed by the Participating Entity during the period of 91 days up to 12 months from the date You were last eligible, You will be treated as a "late enrollee". If You do not qualify for reinstatement and are re-employed by the Participating Entity after 12 months from the date You were last eligible, You will be treated as a new enrollee.]]

[Continuation of Coverage. Benefits for You [and Your Dependent(s)] may continue past the day they would otherwise cease as provided under the Cancellation provision upon payment of the required premium.

[Your Coverage will continue, provided the appropriate premium is paid:

- for up to two (2) months after You cease full-time work due to temporary layoff or leave of absence;
- for up to six (6) months after You cease full-time work due to Sickness or Injury; or until the last day of the month in which the number of hours worked falls below the required minimum].

[Dependent Coverage will continue:

- provided the appropriate premium is paid, under the same conditions above; or
- with no premium required, for up to eighteen (18) months after the end of the month in which Your death occurs.]

[This Coverage will not continue if You begin work for pay or profit with another employer.]

Transfer of Coverage. If indicated on the Schedule of Benefits Page, the following additional terms and conditions apply, [if requested by the Participating Entity], when this Plan replaces a Prior Plan:

- Any person covered under the Prior Plan will be Covered under this Plan on the date the Prior Plan discontinues provided they enroll under this Plan.

- The incontestability provision of this Plan will not apply to a Covered Person who has completed two years of continuous coverage including coverage under the Prior Plan. Statements made as part of an application to a prior insurer by a Covered Person insured under this Transfer of Coverage provision will be considered as statements made to Us.

- We will give credit to total or partial satisfaction of the Pre-Existing Condition limitation for time insured under the Prior Plan.

[- The replacement of a tooth or teeth extracted but not replaced prior to the Covered Person's effective date under the Plan will be Covered provided:
  - the tooth or teeth were extracted and eligible for replacement under the Prior Plan;
  - the tooth is otherwise eligible for replacement under this Plan; and
  - the replacement was completed within the first year of the Covered Person's effective date under the Plan.

- The replacement of full or partial dentures, fixed or removable bridgework within two years of a Covered Person's effective date under the Plan will be Covered provided:
  - other replacement rules listed under the Dental Care provision of the Plan were met; and
  - the Covered Person's coverage was continuous for a combined period of at least two years with the Prior Plan and this Plan.]

SECTION 3.0 PREMIUMS

Premiums. Your premium due is calculated at each premium due date. Premiums are not guaranteed and may change at any time but, where possible, changes will occur on a premium due date. A "grace period" of 31 days is allowed for payment in full of any premium due. All premiums must be paid for Insurance in force during the "grace period". Any portion of the premium elected by and payable by the Participating Entity will not be Your responsibility for payment. During the "grace period" coverage shall continue in force unless You give Us written notice of discontinuance in accordance with the terms of the policy an din advance of the date of discontinuance.

SECTION 4.0 DESCRIPTION OF BENEFITS

[Hospital Income

This benefit provision only applies if it is shown in the Schedule of Benefits Page.

Subject to the terms and conditions of the Plan, We will pay hospital income benefits for You if You become Confined as an Inpatient in a Hospital while Covered under the Plan. The Confinement must be caused by an Injury or Sickness for which Medically Necessary treatment is sought. The hospital income benefit will be the Daily Benefit Amount specified on the Schedule of Benefits Page for each day of such Hospital Confinement subject to the Maximum Benefit specified on the Schedule of Benefits Page.

[For FL Residents: The hospital income benefit payable as described above includes Inpatient Confinement for:

- **the treatment of cleft lip and cleft palate for a Dependent child under age 18. Medically necessary treatment prescribed by a Doctor may include medical, dental, speech therapy, audiology and nutrition services.**

- **dental treatment or surgery provided to a Covered Person if leaving the dental condition untreated will likely result in a medical condition. Such Necessary dental care will be payable for a Covered Person who:**

  - **is a Dependent child under age 8 whose Dentist and Doctor have determined that such Necessary dental treatment should be performed in a Hospital or ambulatory surgical center due to a significantly complex dental condition or a developmental disability in which patient management in the dental office has proven ineffective; or**
  - **has one or more medical conditions that would create significant or undue medical**

risk in the course of delivery of any Necessary dental treatment or surgery if not rendered in a Hospital or ambulatory surgical center.]

Successive Periods of Hospital Confinement. In determining the Maximum Benefit, successive periods of Hospital Confinement resulting from the same Injury or the same or related Sickness will be considered one period of Confinement. If successive periods of Hospital Confinement are separated by [3-12] consecutive months during which You are not Confined, then each Confinement is considered separately.

[Convalescent Facility Benefits. If indicated on the Schedule of Benefits Page, 50% of the Daily Benefit Amount will be payable for a maximum of [1-500] days for You when Confined as an Inpatient for care in a Convalescent Facility within 3 days of a Hospital Confinement lasting at least 3 consecutive days. If You continue to be Confined as an Inpatient for care in a Convalescent Facility beyond the maximum of [1-500] days, no further benefits are payable for the Confinement.]

[ICU/CCU Confinements. If indicated on the Schedule of Benefits Page, the Daily Benefit Amount will be doubled for a maximum of [1-500] days for You when Confined in the Intensive Care Unit of a Hospital, including a Coronary Care Unit. If You continue to be Hospital Confined after the maximum of [1-500] days is exhausted, the Daily Benefit Amount will be payable subject to the Maximum Benefit specified on the Schedule of Benefits Page.]

[Heart Attack/Stroke/Cancer Confinements. If indicated on the Schedule of Benefits Page, the Daily Benefit Amount will be doubled for a maximum of [1-500] days for You when Confined as an Inpatient in a Hospital for the treatment of a heart attack, stroke or cancer. If You continue to be Hospital Confined after the maximum of [1-500] days is exhausted, the Daily Benefit Amount will be payable subject to the Maximum Benefit specified on the Schedule of Benefits Page.]

[Mental Illness/Alcohol or Drug Abuse Confinements. If indicated on the Schedule of Benefits Page, 50% of the Daily Benefit Amount will be payable for a maximum of [1-100] days for You when Confined as an Inpatient in a Hospital for the treatment of Mental Illness or Alcohol or Drug Abuse. If You continue to be Confined as an Inpatient in a Hospital for the treatment of Mental Illness or Alcohol or Drug Abuse beyond the maximum of [1-100] days, no further benefits are payable for the Confinement.]

[These additional benefits, do not increase the Maximum Benefit as specified on the Schedule of Benefits Page. If You are eligible to receive benefits under more than one of the above-described provisions for one Hospital Confinement, benefits will be payable under the provision providing the highest benefit.]**]**

[First Hospital Confinement:

This benefit provision only applies if it is shown in the Schedule of Benefits Page.

Subject to the terms and conditions of the Plan, We will pay a First Hospital Confinement benefit if You become Confined as an Inpatient in a Hospital while Covered under the Plan. The Confinement must be caused by an Injury or Sickness for which Medically Necessary treatment is sought. The First Hospital Confinement benefit will be the amount specified on the Schedule of

Benefits Page. The First Hospital Confinement benefit is a one time benefit per person per Calendar Year for the first Hospital Confinement occurring during a Calendar Year.

[For FL Residents: The First Hospital Confinement benefit payable as described above includes Inpatient Confinement for:

- **the treatment of cleft lip and cleft palate for a Dependent child under age 18. Medically necessary treatment prescribed by a Doctor may include medical, dental, speech therapy, audiology and nutrition services.**

- **dental treatment or surgery provided to a Covered Person if leaving the dental condition untreated will likely result in a medical condition. Such Necessary dental care will be payable for a Covered Person who:**

- **is a Dependent child under age 8 whose Dentist and Doctor have determined that such Necessary dental treatment should be performed in a Hospital or ambulatory surgical center due to a significantly complex dental condition or a developmental disability in which patient management in the dental office has proven ineffective; or**

- **has one or more medical conditions that would create significant or undue medical risk in the course of delivery of any Necessary dental treatment or surgery if not rendered in a Hospital or ambulatory surgical center]**

Successive Periods of Hospital Confinement. Successive periods of Hospital Confinement resulting from the same Injury or the same or related Sickness will be considered one period of Confinement. If successive periods of Hospital Confinement are separated by [3 - 12] consecutive months during which You are not Confined, then each Confinement is considered separately.**]**

[Doctor's Office Visits

This benefit provision only applies if it is shown in the Schedule of Benefits Page.

Subject to the terms and conditions of the Plan, We will pay Doctor's office visit benefits as specified on the Schedule of Benefits Page. Each Doctor's office visit must be for the Medically Necessary care or treatment of an Injury or Sickness. Benefits under this provision are subject to the Maximum Benefit indicated on the Schedule of Benefits Page.

[For FL Residents: The Doctor's Office Visit benefit payable as described above includes treatment for the following:

- **postdelivery care for a mother and her newborn infant. The postdelivery care must include a postpartum assessment and newborn assessment and may be provided at the Hospital, at the Doctor's office, at an outpatient maternity center, or in the home by a qualified licensed heath care professional trained in mother and baby care. The services must include physical assessment of the newborn and mother and the performance of any Medically Necessary clinical tests and immunizations in keeping with prevailing medical standards.**

- **Medically Necessary equipment, supplies and diabetes outpatient self-management**

training and educational services used to treat diabetes when the Covered Person's Doctor certifies that such services are Medically Necessary. Diabetes outpatient self-management training and educational services must be provided under the direct supervision of a certified diabetes educator or a board-certified endocrinologist. Nutrition counseling must be provided by a licensed dietician.

- **non-surgical procedures for prosthetic devices which are incidental to mastectomy.**

- **outpatient surgical follow up care for postsurgical mastectomy care provided by a Doctor. The treating Doctor and the patient may choose whether the most appropriate setting for such care is in a hospital, Doctor's office, outpatient center or the patient's home.**

- **breast reconstructive surgery which is incidental to mastectomy.**

- **the Medically Necessary diagnosis and treatment of osteoporosis for high risk individuals, including but not limited to:**
  - **estrogen-deficient individuals who are at clinical risk for osteoporosis;**
  - **individuals who have vertebral abnormalities;**
  - **individuals who are receiving long-term glucocorticoid (steroid) therapy;**
  - **individuals who have primary hyperparathyroidism; and**
  - **individuals who have a family history of osteoporosis.**

- **treatment of cleft lip and cleft palate for a Dependent child under age 18. Medically necessary treatment prescribed by a Doctor may include medical, dental, speech therapy, audiology and nutrition services.**

- **Medically Necessary prescription and nonprescription enteral formulas for home use for the treatment of inherited diseases of amino acid, organic acid, carbohydrate or fat metabolism as well as malabsorption originating from congenital defects present at birth or acquired during the neonatal period. Coverage for inherited diseases of amino acids and organic acids includes food products modified to be low protein, in an amount not to exceed $2,500 annually for any Covered Person, through the age of 24. No Pre-Existing Condition limitation or exclusion may prevent the payment of these benefits.]**

[Benefits are not payable under this provision if they are payable under the Doctor's Office Visits for Wellness Care provision.]

[Benefits are not payable under this provision if they are payable under the Child Wellness Care provision.]**]**

[Doctor's Office Visits for Wellness Care

This benefit provision only applies if it is shown in the Schedule of Benefits Page.

Subject to the terms and conditions of the Plan, We will pay Doctor's office visit(s) for Wellness Care benefits as specified on the Schedule of Benefits Page.

"Wellness Care" means services provided by, or under the supervision of, a single Doctor during the course of [1-5] visit(s) for the routine physical evaluation and not because of Injury or Sickness**.**

[Benefits are not payable under this provision if they are payable under the Doctor's Office Visits provision.]

[Benefits are not payable under this provision if they are payable under the Child Wellness Care provision.]**]**

[Child Wellness Care

This benefit provision only applies if it is shown in the Schedule of Benefits Page.

Subject to the terms and conditions of the Plan, We will pay a child wellness care benefit as specified on the Schedule of Benefits Page for a Dependent child for Well Child Care from the moment of birth to Age 6 years. Child wellness benefits will be limited to one Doctor's visit at the following specified Age intervals:

- birth,
- 2 months,
- 4 months,
- 6 months,
- 9 months,
- 12 months,
- 18 months,
- 2 years and
- annually thereafter, up to Age 6 years.

"Well Child Care" means the periodic review of a child's physical and emotional status. Well Child Care will only be covered to the extent that the services are provided by, or under the supervision of, a single Doctor during the course of one visit. Well Child Care may include the following:

- patient history;
- complete physical examination;
- developmental assessment;
- anticipatory guidance;
- appropriate immunizations;
- laboratory tests; and
- hearing and vision screening

in keeping with prevailing medical standards**.**

[Benefits are not payable under this provision if they are payable under the Doctor's Office Visits for Wellness Care provision.]

[Benefits are not payable under this provision if they are payable under the Doctor's Office Visits provision.]**]**

[Diagnostic Testing and X-ray

This benefit provision only applies if it is shown in the Schedule of Benefits Page.

Subject to the terms and conditions of the Plan, We will pay diagnostic testing and x-ray benefits as specified on the Schedule of Benefits Page [with the exception of 1 diagnostic test or x-ray per Calendar Year which may be for Wellness Care]. Such services must be performed in the Doctor's office or an outpatient facility.

Benefits for outpatient diagnostic x-ray and lab tests will be paid only when ordered or performed by a Doctor.

["Wellness Care" means services provided by, or under the supervision of, a single Doctor during the course of a visit for the routine physical evaluation and not because of Injury or Sickness.]

[Benefits are not payable under this provision if they are payable under the Child Wellness Care provision.]**]**

[For FL Residents: The Diagnostic Testing or X-ray benefits payable as described above include diagnostic testing and x-rays for the following:

- **postdelivery care for a mother and her newborn infant. The postdelivery care must include a postpartum assessment and newborn assessment and may be provided at the Hospital, at the Doctor's office, at an outpatient maternity center, or in the home by a qualified licensed heath care professional trained in mother and baby care. The services must include physical assessment of the newborn and mother and the performance of any Medically Necessary clinical tests and immunizations in keeping with prevailing medical standards.**

- **mammograms as follows:**
  - **a baseline mammogram for any woman age 35 through 39 years;**
  - **a mammogram every 2 years for any woman age 40 through 49 years or more frequently if recommended by a Doctor;**
  - **a mammogram every year for any woman age 50 years or older;**
  - **one or more mammograms per year, based on a Doctor's recommendation, for any woman who is at risk for breast cancer because of a personal or family history of breast cancer, a history of biopsy-proven benign breast disease, having a mother, sister or daughter who has or has had breast cancer, or because a woman has not given birth before age 30.**

  Except as noted above for mammograms performed more frequently than every 2 years for women age 40-49 years, no prescription is required for testing if the mammogram is performed in an office, facility or health testing service that uses radiological equipment registered with the Department of health for breast cancer screening.

- **Medically Necessary diagnosis and treatment of osteoporosis for high risk individuals, including but not limited to:**
  - **estrogen-deficient individuals who are at clinical risk for osteoporosis;**
  - **individuals who have vertebral abnormalities;**
  - **individuals who are receiving long-term glucocorticoid (steroid) therapy;**
  - **individuals who have primary hyperparathyroidism; and**

- **individuals who have a family history of osteoporosis.**

- **the treatment of cleft lip and cleft palate for a Dependent child under age 18. Medically necessary treatment prescribed by a Doctor may include medical, dental, speech therapy, audiology and nutrition services.]**

[Surgery

This benefit provision only applies if it is shown in the Schedule of Benefits Page.

Subject to the terms and conditions of the Plan, We will pay surgery and anesthesia benefits. The surgery must be Medically Necessary treatment performed because of an Injury or Sickness. Inpatient surgery must be performed in the operating room of a Hospital.**]**

[For FL Residents: Surgery benefits payable as described above include surgical procedures for the following:

- **prosthetic devices which are incidental to mastectomy.**

- **breast reconstructive surgery which is incidental to mastectomy.**

- **treatment of cleft lip and cleft palate for a Dependent child under age 18. Medically necessary treatment prescribed by a Doctor may include medical, dental, speech therapy, audiology and nutrition services.**

- **dental treatment or surgery provided to a Covered Person if leaving the dental condition untreated will likely result in a medical condition. Such Necessary dental care will be payable for a Covered Person who:**

- **is a Dependent child under age 8 whose Dentist and Doctor have determined that such Necessary dental treatment should be performed in a Hospital or ambulatory surgical center due to a significantly complex dental condition or a developmental disability in which patient management in the dental office has proven ineffective; or**

- **has one or more medical conditions that would create significant or undue medical risk in the course of delivery of any Necessary dental treatment or surgery if not rendered in a Hospital or ambulatory surgical center.]**

[Emergency Room

This benefit provision only applies if it is shown in the Schedule of Benefits Page.

Subject to the terms and conditions of the Plan, We will pay emergency room benefits for [Injury] [and][or] [Sickness]. Such services must be Medically Necessary and provided on an Emergency basis for [an Injury] [or] [a Sickness] that does not result in Hospital Confinement. All services related to the emergency room visit, including but not limited to labs, x-rays, diagnostic testing, or attending Doctors, are payable under this benefit and subject to the Maximum Benefit shown on the Schedule of Benefits Page.**]**

[Ambulance

This benefit provision only applies if it is shown in the Schedule of Benefits Page.

Subject to the terms and conditions of the Plan, We will pay ambulance benefits as specified on the Schedule of Benefits Page and subject to the Maximum Benefit as shown. Each ambulance trip must be for the Medically Necessary care or treatment of an Injury or Sickness.**]**

[Vision Care

This benefit provision only applies if it is shown in the Schedule of Benefits Page.

Subject to the terms and conditions of the Plan [and after being Covered under the Plan for at least 30 days], We will pay for vision care benefits if You incur Covered Vision Expenses while Covered under the Plan.

"Covered Vision Expenses" means vision care and services which are:

- provided by a Doctor for one routine eye exam during a Calendar Year; and
- for one pair of eyeglass lenses and frames or one pair of contact lenses within 2 consecutive Calendar Years when prescribed by a Doctor. For disposable contact lenses, We will pay the amount specified on the Schedule of Benefits Page subject to the 2 consecutive Calendar Years period regardless of the number or supply purchased.**]**

[Disability Income

This benefit provision only applies if it is shown in the Schedule of Benefits Page.

The following definitions are specific to terms used in this provision:

"Basic Salary," as referenced on the Schedule of Benefits Page, means:

- the average of Your regular weekly earnings from the Participating Entity over the 26 weeks prior to becoming Totally Disabled ; or
- if working for the Participating Entity for less than 26 weeks, the average of Your regular weekly earnings from the Participating Entity since Your date of hire.

It does not include bonuses, overtime, commissions or any other extra compensation. However, if the You are a salesperson, compensated, in whole or in part, by commissions, Your earnings include their commissions.

"Regular Care" means, according to generally accepted medical standards, You personally visit a Doctor as often as is medically required to effectively manage and treat Your disabling condition(s) and are receiving appropriate treatment and care. Treatment and care for the Sickness or Injury causing the Your disability must be given by a Doctor whose specialty or experience is appropriate.

"Total Disability" or "Totally Disabled" means, as a direct result of Injury or Sickness, You are unable to perform all of the substantive and material duties of their Occupation [and they are not engaged in any occupation for wage or profit].

"Occupation" means the occupation, as generally performed in the workforce, that You are routinely performing when their Total Disability began. It does not specifically mean the job You are performing for the Participating Entity or at a specific location.

Subject to the terms and conditions of the Plan, We will pay the disability income benefit amount shown on the Schedule of Benefits Page, after the completion of the Benefit Waiting Period as indicated on the Schedule of Benefits Page, when We receive proof that You are:

- Totally Disabled; and
- under the Regular Care of a Doctor.

The Injury or Sickness must occur and Your Total Disability must begin while You are Covered under the Plan. Your Total Disability is determined relative to their ability or inability to work. It is not determined by the availability of a suitable position with an employer. The loss of a professional or occupational license or certification for any reason does not, in and of itself, constitute Total Disability.

Your disability income benefit amount will cease upon the first of the following to occur:

- You are no longer Totally Disabled;
- You have reached the Maximum Benefit Period shown on the Schedule of Benefits Page;
- 31 days following Our request if You do not provide satisfactory proof of their continued Total Disability; or
- 31 days following Our request if You refuse to submit to an examination by a Doctor of Our choice.

[Integration Of Benefits. Your disability income benefit amount will be reduced by Other Sources Of Income which may be available to You during Total Disability, but only to the extent necessary that total income from this plan and Other Sources of Income does not exceed [50% - 75%] of Your Basic Salary prior to Total Disability when averaged over the 12 months preceding Your Total Disability. In no event will the Your disability income benefit amount be reduced to less than $50.

"Other Sources Of Income" means Social Security primary and dependent benefits, Workers' Compensation, payment from any employer or business, retirement benefits, disability benefits under any association or employer, or insurance plans as a result of Total Disability, motor vehicle plan which provides disability benefits under any state law but only as long as the law does not prohibit such a deduction.]

Recurrent disability. If, after a period of Total Disability ends, You:

- return to being Actively at Work for a period of 26 weeks or less;
- become Totally Disabled within the 26 week period from the same or related cause; and
- are continuously Covered under this Plan;

the later period of Total Disability will be considered a continuation of the prior period of Total Disability. Your disability income benefit amount, if a benefit is payable, will be the same as for the prior Total Disability.

If after a period of Total Disability ends, You:

- return to being Actively at Work; and
- then become Totally Disabled again from a cause or causes unrelated to Your prior Total Disability;

the later period of Total Disability will be considered a new period of Total Disability and You must satisfy the benefit waiting period before benefits become payable.

If after a period of Total Disability ends, You:

- do not return to being Actively at Work; and
- then become Totally Disabled again from a cause or causes unrelated to their prior Total Disability;

the later period of Total Disability will be considered a continuation of the prior period of Total Disability.

Under no circumstances will the benefits payable for any one period of Total Disability exceed the Maximum Benefit Period as shown on the Schedule of Benefits Page**.**] **]**

[Dental Care

This benefit provision only applies if it is shown in the Schedule of Benefits Page.

Subject to the terms and conditions of the Plan, We will pay dental benefits for Covered Dental Expenses incurred while You are Covered under the Plan. The benefit amount(s) and Maximum Benefit(s) payable under the Plan are shown on the Schedule of Benefits Page. Some Covered Dental Expenses are subject to a minimum time period requirement, for Coverage under this Plan before benefits are payable; refer to the provision for each type/category of dental care.

[For FL Residents: Dental benefits payable as described in this provision include dental treatment or surgery provided to a Covered Person if leaving the dental condition untreated will likely result in a medical condition. Such Necessary dental care will be payable for a Covered Person who:

- **is a Dependent child under age 8 whose Dentist and Doctor have determined that such Necessary dental treatment should be performed in a Hospital or ambulatory surgical center due to a significantly complex dental condition or a developmental disability in which patient management in the dental office has proven ineffective; or**
- **has one or more medical conditions that would create significant or undue medical risk in the course of delivery of any Necessary dental treatment or surgery if not rendered in a Hospital or ambulatory surgical center.]**

Type 1 - Preventive & Diagnostic. **Benefits are available on Your effective date of coverage.**

- Oral Exams - including diagnosis and prophylaxis, but not more than two examinations during any Calendar Year.
- X-rays:
  - Full mouth or panoramic X-rays not to exceed one series in any three consecutive Calendar Year periods,
  - Bitewing X-rays not more than two times per Calendar Year.
- [Sealants:
  - Limited to children fourteen (14) years of Age or Younger;
  - Only for a tooth or teeth posterior to cuspids; and
  - Not more than one application in a Calendar Year per tooth.]
- [Fluoride Treatment - limited to children fourteen (14) years of Age or Younger.]
- Space Maintainers.

Type 2 - Major Restorative. **You must be Covered under this Plan for at least [6-24] months before the following are considered Covered Dental Expenses:**

- Crowns, inlays, onlays.
- Prosthetics - prefabricated crown or cast post and core.
- Prosthetics, including bridges and dentures as follows:
  - The initial installation, or addition to full or partial dentures, fixed or removable bridgework will be eligible, provided:
    - The installation or addition was required as a result of an extraction of a Natural Tooth when Necessary while You are Covered;
    - The installation or addition includes the replacement of an extracted tooth or teeth; and
    - The denture or bridgework was completed within twelve (12) months following the date of extraction.

    Dentures and bridgework are considered initially installed if they do not replace any existing dentures or bridgework.

- The replacement or alteration of full or partial dentures, fixed or removable bridgework will be considered for payment when:
  - Necessary;
  - Incurred while Covered under the Plan; and
  - Completed within twelve (12) months after one of the following:
    - An Injury which requires surgical treatment; or
    - Oral surgical treatment which involves the repositioning of muscle attachments, or the removal of a tumor, cyst, torus, or redundant tissue.

- The replacement of a full or partial denture or fixed bridgework when required because of structural change in the mouth or removable bridgework that was no longer serviceable provided the replacement:
  - Is made five years or more after the installation date of the denture or bridgework;
  - In no event less than two years after Your effective date; and
  - Performed while Covered under the Plan.

Covered Dental Expenses for fixed partial dentures, crowns, inlays or onlays, as outlined above, will be considered incurred on the date of preparation of the tooth or teeth involved, and for removable partial or complete dentures, on the date the first impression was taken.

Type 3 - Minor Restorative. **Benefits are available on Your effective date of coverage.**

- Repair of crown, denture or bridge including relining or rebasing.
- Restorations - fillings of amalgam or synthetic process.
- Tissue conditioning.

Type 4 - Endodontics. **Benefits are available on Your effective date of coverage.**

- Root canal; apicoectomy; root amputation.
- Therapeutic pulpotomy; retrograde filling; apexification; hemisection.

A charge will be deemed incurred on the date the tooth was opened for root canal therapy.

Type 5 - Periodontics. **You must be Covered under this Plan for at least [6-24] months before the following are considered Covered Dental Expenses and benefits payable are subject to the Calendar Year maximum and specific periodontal maximum shown on the Schedule of Benefits Page:**

- Gingivectomy (per quadrant), Gingivoplasty (per quadrant), scaling (including root planing per quadrant), splinting, root planing.
- Gingivectomy (per tooth).
- Osseous surgery; soft tissue grafts; gingival flap procedure.
- Gingival curettage (per quadrant).

Type 6 - Oral Surgery. **You must be Covered under this Plan for at least [6-24] months before the following are considered Covered Dental Expenses:**

Level 1:
- Removal of exostosis; surgical extraction of bony impaction.

Benefits are available on Your effective date of coverage:
Level 2:
- Biopsy of oral tissue (soft or hard); alveoloplasty with or without extraction (per quadrant); surgical removal of erupted tooth or residual roots; frenulectomy (frenectomy; frenotomy); excision hyperplastic tissue; removal of impacted tooth (soft tissue).

Level 3:
- Simple (routine) Extractions.
- Incision and drainage of abscess (intraoral or extraoral soft tissue); removal of exposed roots.

Type 7 - Anesthesia. **You must be Covered under this Plan for at least [6-24] months before the following are considered Covered Dental Expenses:**

- Intravenous sedation; general.

[Type 8 - Comprehensive Orthodontic Treatment. **You must be Covered under this Plan for at least [6-24] months before the following are considered Covered Dental Expenses. Benefits payable are not subject to the Calendar Year maximum but are subject to the Comprehensive Orthodontic Treatment maximum shown on the Schedule of Benefits Page:**

- Orthodontic appliances - furnishing and attachment of any Necessary orthodontic appliance.

Covered Dental Expenses for Comprehensive Orthodontic Treatment will be paid as follows:
- An initial amount equal to one-fourth (1/4) of the Covered Dental Expenses in a Treatment Plan. This initial amount covers the fee charged in the Treatment Plan for:
  - Diagnosis;
  - Evaluation; pre-orthodontic treatment; or
  - The insertion of orthodontic appliances.

- Upon receipt of proof of continued treatment, the balance will be paid in equal installments every 6 months. If the course of treatment is less than 18 months, upon notification of the end of treatment, We will pay the amount of the balance of the scheduled benefit amount at that date within 30 days.

- If a Treatment Plan for Comprehensive Orthodontic Treatment is begun before Your effective date under this Plan but expenses are incurred after Your effective date under this Plan, benefits will be calculated as a pro-rata proportion for the months remaining in the projected period of treatment and paid in 3 equal installments every 6 months. If the course of treatment is less than 18 months, upon notification of the end of treatment, We will pay the amount of the balance of the scheduled benefit amount at that date within 30 days.]**]**

[<u>Accidental Death [& Dismemberment]</u>:

This benefit provision only applies if it is shown in the Schedule of Benefits Page.

The Principal Sum amount of the Accidental Death [& Dismemberment] Insurance benefit is shown in the Schedule of Benefits Page. The percentage of the Principal Sum shown in the schedule below will be paid to [Your estate] [or] [Your Covered Dependent's estate] when We receive due proof of [You] [or] [Your Covered Dependent's] Accidental death [or to the [Your] [or] [Your Covered Dependent] when We receive due proof of [You] [or] [Your Covered Dependent's] Accidental Dismemberment].

The total amount paid for [You] [or] [Your Covered Dependent] for all covered Accidents will not be more than the Principal Sum except for any specified additional benefits described elsewhere in this section. A loss incurred prior to this Insurance going into force will not be included in determining the amount to be paid. A loss must occur within 365 days of the Accident and [You] [or] [Your Covered Dependent] must be Covered under the Master Policy at the time of death [or Accidental Dismemberment] in order for benefits to be payable.

	Percentage of Principal Sum Payable
Accidental death	100%
[Accidental dismemberment	
[for loss of two hands, two feet or sight of both eyes	[25-100 %]
[for loss of one hand and one foot	[25-100 %]
[for loss of one hand and sight of one eye	[25-100 %]
[for loss of one foot and sight of one eye	[25-100 %]
[for loss of speech and hearing in both ears	[25-100 %]
[for total paralysis of both upper and lower limbs (quadriplegia)	[25-100 %]
[for loss of one arm or one leg	[25-100 %]

[for total paralysis of both lower limbs (paraplegia)	[25-100 %]
[for loss of one hand or one foot	[25-100 %]
[for loss of sight of one eye	[25-100 %]
[for loss of speech or hearing in both ears	[25-100 %]
[for total paralysis of upper and lower limbs of one side of body (hemiplegia)	[25-100 %]
[for loss of thumb and index finger of same hand	[25-100 %]
[for loss of hearing in one ear	[25-100 %]]

[Family Plan Insurance. The Family Plan, if selected by the You at the time of Your enrollment, provides additional coverage for [You] [and] [all of Your eligible Dependents]. Your spouse [or Domestic Partner] and the children at the time of loss constitute Your family. The composition of the Your family at the time of loss determines the benefit payable.

Benefits are calculated as a percentage of Your Principal Sum amount as follows:

If, at the time of Accidental death, Your family consists of:

(a)You and Your spouse [or Domestic Partner] (no children)

[You	100%]
[Spouse [or Domestic Partner]	50%]

(b) You, Your spouse [or Domestic Partner] and child(ren)

[You	100%]
[Spouse [or Domestic Partner]	40%
[Each child [for Accidental death]	10%]
[Each child for Accidental Dismemberment	50%]]

(c) You and Your child(ren) (no spouse [or Domestic Partner])

[You	100%]
[Each child [for Accidental death]	15%]
[Each child for Accidental Dismemberment	75%]]

[Exposure and Disappearance. If [You] [or] [Your Covered Dependent] is Accidentally and unavoidably exposed to the elements and if, as a result of this exposure, He suffers loss of life [or Dismemberment] which would otherwise be insured hereunder, then the loss will be considered to have resulted from Accidental bodily Injury.

If, as a result of the Accidental destruction or disappearance of a conveyance in which He is riding, and [You] [or] [Your Covered Dependent] disappears and if His body is not found within a year of the date of this event, then it will be presumed, if there is no evidence to the contrary, that [You] [or] [Your Covered Dependent] has suffered loss of life because of Accidental bodily Injury.]**]**

SECTION 5.0 EXCLUSIONS AND LIMITATIONS

Exclusions and Limitations Applicable to All Benefits Provided Under the Plan [(except Accidental Death [& Dismemberment])]

Benefits are not provided for any charges or expenses incurred by a Covered Person which results directly or indirectly, wholly or partly from:

[1. Insurrection, rebellion, participation in a riot, commission of or attempting to commit an assault, battery, felony, or act of aggression.]
[2. War or any act of war, whether declared or undeclared, or Sickness contracted or Accidental bodily Injury occurring while on full-time active duty in the Armed Forces of any country or combination of countries.]
[3. Occupational Injury or Sickness or any Injury or Sickness otherwise covered by any Workers' Compensation Act, Occupational Disease Law or similar law.]
[4. Operating a motor vehicle under the influence of alcohol as evidenced by a blood alcohol level in excess of the state legal intoxication limit.]
[5. Care or treatment related to intentionally self-inflicted Injury or self-induced Sickness.]
[6. Charges for which there is no legal obligation to pay, or no charge is made, or in the absence of Coverage no charge would be made.]
[7. Charges incurred after termination of Coverage.]
[8. Charges for care or services furnished by any agency or program funded by federal, state or local government except Medicaid.]
[9. Charges which are not Medically Necessary for treatment of Sickness or Injury.]
[10. Unless specifically provided for in the Plan, charges for routine physicals or exams or routine immunizations when no Injury or Sickness is present.]
[11. Charges for medical care, services, or supplies which are not furnished or prescribed by a Doctor.]
[12. [Charges for Experimental or investigational treatment, procedures for research purposes, or practices when not generally recognized as accepted medical practices. **[For FL Residents: This exclusion is not applicable to bone marrow transplant procedures when recommended by the referring and treating Doctors and its use is determined to be accepted within the appropriate oncological specialty and not Experimental according to rules adopted by Florida's Agency for Health Care Administration.]]**
[13. Charges for care, treatment, services or supplies that are not approved or accepted as essential to the treatment of an Injury or Sickness by any of the following:]
- [The American Medical Association;]
- [The U.S. Surgeon General;]
- [The U.S. Department of Public Health;]
- [The National Institute of Health.]

[14. Charges related to Cosmetic surgery except:]
[- To repair disfigurement because of an Accidental bodily Injury which occurs while Covered under this Plan;]
[- For reconstructive surgery **[For FL Residents: including breast reconstructive surgery and prosthetic devices incident to a Medically Necessary mastectomy performed as determined by a Doctor; and]** because of mastectomy which is performed within 12 months of the date of a mastectomy, provided that the mastectomy is because of malignancy and is performed while Covered under this Plan; and]
[- For treatment of congenital defects in a child born to You while Covered under this Plan.]

[15. Unless dental care benefits are included in this Plan, dental care or oral surgery [except for closed or open reduction of fractures or dislocation of the jaw].]

[16. Unless specifically provided in the Plan, charges for treatment of Mental Illness.]
[17. Unless specifically provided in the Plan, charges for treatment of Alcohol or Drug Abuse.]
[18. Unless specifically provided in the Plan, charges for refractions, eyeglasses or their fitting.]
[19. Hearing aids or their fitting.]
[20. Charges in connection with obesity, weight reduction, or dietetic control, except for morbid obesity or disease etiology.]
[21. Charges for reversal procedures in connection with previous male or female sterilization.]
[22. Charges for services related to educational or vocational testing or training.]
[23. Any charges for abortions which are not Medically Necessary.]
[24. Any charges for outpatient food, food supplements, or vitamins.]
[25. Any charges for prescription drugs or durable medical equipment.]
[26. Surgery to correct vision problems which are not caused by a Sickness or Injury.]
[27. Charges for treatment of male or female infertility; in vitro and in vivo fertilization of an ovum; or artificial insemination including but not limited to:
1. [Drugs and medicines;]
2. Diagnostic and surgical procedures including but not limited to:
- [Aspiration of ovarian cysts;]
- [Harvesting or obtaining eggs;]
- [Other surgical treatment of infertility;]
- [Diagnostic laboratory and pathology procedures; and]
- [Diagnostic radiology, nuclear medicine and ultra sound procedures.]]
[28. Charges made by a surgeon, nurse, Dentist or Doctor who:]
- [Normally lives with You;]
- [Is a member of Your family; or]
-[Is Your Participating Entity or another person of the Participating Entity; or]
- [Is contracted for or by a union, employee benefit association, trustee, or similar organization or the employee of a clinic contracted for or by any such organization.]
[29. Charges for Custodial Care.]
[30. Charges for care, treatment, services, supplies or Confinements primarily for the convenience of You, Your Doctor, Your family or other Providers.]
[31. Charges related to smoking cessation.]
[32. Charges for the treatment of the following:]
- [Codependency;]
- [Social, occupational, or religious maladjustments;]
- [Compulsive gambling;]
- [Chronic marital or family problems when not related to the primary focus of treatment which must be a diagnosable mental disorder.]
[33. Treatment received outside of the United States except for Emergency treatment while traveling.]
[34. The processing of nuclear fission or fusion, or the processing, use, handling or transporting of radioactive material, including but not limited to nuclear reactors or any weapon of war or explosive device employing nuclear fission or fusion.]
[35. Charges for treatment or services for Temporomandibular Joint (TMJ) Syndrome, orofacial, or myofascial syndrome whether medical or dental in scope.] [**For FL Residents: Charges for treatment or services for Temporomandibular Joint (TMJ) Syndrome, orofacial, or myofascial syndrome whether medical or dental in scope. This exclusion will not apply if, under accepted medical standards, such treatment is Medically Necessary to treat conditions caused by congenital or developmental deformity, disease or injury. This does not, however, require coverage for care or treatment of the teeth or gums, for**

intraoral prosthetic devices, or for surgical procedures for Cosmetic purposes.]

[**Exclusions Specific to the Vision Care Benefits of the Plan**

In addition to the above, benefits are not provided for:
- Any medical or surgical treatment of the eye.
- Sunglasses, plain or prescription; or safety lenses or goggles.
- Orthoptics, vision training or aniseikonia.]

[Limitation/Exclusion Specific to [Hospital Income] [, First Hospital Confinement] [, Surgery] [and] [Disability Income] Benefits of the Plan

Benefits are not provided for Injury or Sickness which results directly or indirectly, wholly or partly from Pre-Existing Conditions until Covered under the Plan for [6-24] continuous months.]

[Exclusions Specific to Dental Care Benefits of the Plan

Benefits are not provided for any charges or expenses incurred which result directly or indirectly, wholly or partly from:
1. Replacement of a tooth or teeth extracted prior to Your effective date unless the replacement satisfies one of the conditions listed under Covered Dental Expenses.
2. Dentures, crowns, inlays, onlays, bridgework or appliances or services for increasing vertical dimensions.
3. Denture or bridgework adjustments.
4. Replacement of a lost or stolen prosthesis or for a duplicate prosthesis.
5. Oral hygiene, diet or plaque control instructions and programs.
6. Athletic mouth guards.
7. Temporary denture or bridge.
8. Your failure to appear as scheduled for an appointment.
9. Tooth re-implantology not resulting from an Accident.
10. Drugs, other than injectable antibiotics administered by a Dentist as a result of dental treatment.
11. Procedures, services, or supplies, which do not meet accepted standards of dental practice.
12. Treatment initiated while not Covered under the Plan, except for Comprehensive Orthodontic Treatment.
13. Expenses which are not included in the Covered Expenses for Dental Care provision**.]**

[**Exclusions Specific to Accidental Death [& Dismemberment] Benefits of the Plan**

Benefits are not provided for any Accidental Death [or Accidental Dismemberment] which results directly or indirectly, wholly or partly from:
1. [Suicide or intentional self-inflicted Injury or any attempt thereat];
2. [Sickness, disease, or bodily or mental infirmity or any medical or surgical treatment thereof. However, bacterial infection resulting from an Accidental cut or wound or Accidental ingestion of a poisonous food substance are not excluded];
3. [Committing or attempting to commit a criminal offense or engaging in an illegal occupation, rebellion or riot];

4. [Accidental bodily Injury occurring while You are serving on full-time active duty for more than 30 days in the Armed Forces of any nation. However, Reserve or National Guard active duty for training is not excluded];
5. [War, whether declared or not, or any act of war or insurrection];
6. [Operating, riding in, or descending from any aircraft, except when riding solely as a passenger on an aircraft holding a valid airworthiness certificate issued by the appropriate authority, or as a passenger or crew member in a military aircraft not involved in an area of hostilities, declared or undeclared];
7. [Operating any motorized vehicle if, at the time of driving, Your blood alcohol level is greater than the legal limit]; or
8. [Use of narcotic or hallucinogenic drugs, unless prescribed by a Doctor**.]**

SECTION 6.0 CLAIM PROVISIONS

Workers' Compensation. This Plan is not in place of and does not affect any requirement for such coverage by workers' compensation insurance.

Notice of Claim. Written notice of claim must be given to Us within 20 days after a loss occurs, or as soon thereafter as possible. The notice can be given to the administrator or directly to Us at Markel Insurance Company, [P.O. Box 3870 Glen Allen VA 23058-3870]. Notice should include the Your name and policy number. Failure to give notice within the 20 days will not invalidate or reduce any claim if it can be shown that notice was given as soon as reasonably possible.

Claim Forms. When We receive notice of claim, We will send Proof of Loss forms. If We do not send these forms within [15] days, You can meet the Proof of Loss requirement by giving Us a written statement of the nature and extent of loss within the time limit in the Proof of Loss section.

Proof of Loss. Written proof of loss must be given to Us within [90] days after such loss. We will not deny or reduce any claim because proof is not filed within this time, if it is filed as soon as reasonably possible. In any event, the proof required must be given, unless the claimant is legally incapacitated, within [12] months of the date of loss.

Time of Payment of Claims. After receiving written proof of loss, We will immediately pay all benefits as they accrue.

Payment of Claims. After receiving written proof of loss, We will pay all benefits to You, if living, or, in the event of Your death, Your estate [or Your assignee. When We receive proper proof of claim from a Provider, We may pay benefits to that Provider for expenses incurred by You. No benefits will be paid to a Provider if such benefits have been paid to You]. It is not required that the service be rendered by a particular Hospital or person.

Discontinuance of the Master Policy will not prejudice any claim incurred while the Master Policy is in force.

Physical Examination. We, at Our expense, have the right to have any individual examined by a Doctor of Our choice as often as reasonably necessary while a claim is pending.

Legal Action. No legal action may be brought to recover on this Plan: (a) within 60 days after written proof of loss has been given as required; or (b) after 3 years from the time written proof of loss is required, or after the expiration of the applicable statute of limitations, if greater.

[For FL Residents:
Legal Action. No legal action may be brought to recover on this certificate within 60 days after written proof of loss has been given as required by this certificate. No such action may be brought after the expiration of the applicable statute of limitations from the time written proof of loss is required to be given, which in no case will be less than 3 years.

NOTICE: Should any dispute arise about Your coverage or about a claim that You have filed, You may contact Us at the number shown below. This notice is for information only and does not become a part or condition of the certificate.

FOR INFORMATION, CALL:
[1-800-431-1270]]

SECTION 7.0 GENERAL PROVISIONS

Incontestability. We will not contest the validity of this Policy after it has been in force for two years from its effective date. No statement made by a Covered Person will be used to contest the validity of any insurance after it has been in force for two years unless the statement is contained in a written instrument signed by You; except for non-payment of premiums exclusive of any period(s) the person was totally disabled.

Changes in Benefit Amounts. Each Covered Person is classified and His benefit amount is determined on the date:

- [He becomes Covered; and
- shown in this Plan for each change in classification or earnings, if the amount is based on either of them; or
- the Plan is amended.]

[If the change or amendment results in an increase in Coverage, the amount will not increase if You are not Actively at Work. The increase will not take place until the day after You are Actively at Work.]

[In addition, no increase in Coverage will take place for a Dependent who is not performing the normal daily activities of persons who are the same Age and gender. The increase will not take place until the day after the Dependent resumes normal duties and activities.]

[Participating Entity as Agent. The Participating Entity is not Our agent in the administration of this Plan. Any action taken by the Participating Entity (other than the receipt of a claim form) which has not been specifically authorized by Us will not be binding on Us.]

Master Policy Changes. The Master Policy under which You are provided Coverage may be changed in whole or in part by Us at Our discretion and, in certain circumstances, upon agreement by Us [and the Participating Entity] and/or Master Policyholder. No other person, including an agent, may change the Master Policy or waive any part of it. The consent of any Covered Person is

not required.

Assignment. You may [not] assign any interest in the benefits provided by this Plan. [No assignment is binding on Us unless We receive it in writing. We are not responsible for the validity or effect of any assignment.]

Money Payable. All money payable by or to Us is to be paid in the lawful currency of the United States of America.

Time Effective. For any dates used in this document, the effective time shall be 12:01 A.M. at Your address.

Examination of the Master Policy. A copy of the Master Policy may be examined at Our Home Office, at the office of the trustee, or at the Plan Administrator.

Conformity with State Statutes. Any provision of the Master Policy which, on its effective date, is in conflict with the statutes of the Commonwealth of Virginia or in the state which the Covered Person resides, is hereby amended to conform to the minimum requirements of such statutes.

Entire Contract. The policy, certificate, endorsements, and any application constitute the entire contract. A copy of any application shall be attached to the policy, all statements made by You shall be deemed representations not warranties, and no written statement made by any person shall be used in any contest unless a copy of the statement is furnished to the person or to his beneficiary or personal representative.

SECTION 8.0 DEFINITIONS

Accident, Accidental, or Accidentally means a sudden, unexpected and unintended event, which is identifiable and caused solely by a physical force resulting in Injury to a Covered Person. Accident, Accidental or Accidentally does not include a loss due to disease or Sickness. **[For FL Residents: Accident, Accidental, or Accidentally means a sudden, unexpected and unintended event, which is identifiable event, which is identifiable and caused solely by an external physical force resulting in Injury to a Covered Person. Accident, Accidental or Accidentally does not include a loss due to health condition or health impairment**.]

[Actively at Work means that You are performing all the normal duties of Your job at Your normal place of business, if not employed, are performing the normal daily activities of persons of like Age and gender.]

Age means age at last birthday.

Alcohol or Drug Abuse means anything classified as alcohol or drug abuse or dependency in the International Classification of Diseases 9th Revision, Clinical Modification, Volume I, (ICD-9-CM), as it now exists or as amended from time to time.

Calendar Year refers to the period from January 1 through December 31 of the same year.

[**Comprehensive Orthodontic Treatment** means one course of treatment for Class I, II or

III malocclusion as defined by American Dental Association standards as it now exists or as amended from time to time.]

Confinement or Confined as it applies to any person in a Hospital or Convalescent Facility, means being charged as an Inpatient.

Convalescent Facility means an institution which:
- is legally qualified and licensed to operate as a convalescent facility;
- charges for its services;
- operates under the supervision of a staff of one or more licensed Doctors;
- provides 24-hour daily nursing service by registered graduate nurses on duty or call;
- maintains a daily medical record for each patient;
- has Emergency care provided by a licensed Doctor; and
- has a written agreement with one or more Hospitals providing for the transfer of patients and medical records between the Hospital and the convalescent facility.

Cosmetic means surgery, supplies or other treatment, the primary purpose of which is to improve the Covered Person's physical appearance.

Coverage or Insurance refers to the various benefits described in this document.

Covered means insured under this Plan.

[**Covered Dental Expense(s)** means Necessary charges for services, supplies and treatment for dental care determined for a benefit to which a Covered Person is entitled, as shown in the Description of Benefits section and not excluded under "Exclusions and Limitations." Limitations and reductions may apply to certain Covered Dental Expenses.]

Covered Person means You or Your Covered Dependent[s].

Custodial Care means services (including room and board) or supplies which:
- are chiefly designed to assist a person with the activities of daily life; and
- cannot reasonably be expected to greatly improve a medical condition.

Dentist means a person who is:
- Licensed to practice dentistry and acting within the scope of that license; or
- Any other Doctor furnishing any dental care He is licensed to perform.

[**Dependent** means a person who is designated by You who may become Covered or is entitled to benefits under the Plan if He is one of the following:
- spouse [or Domestic Partner] (if not legally separated or divorced from the You); or
- unmarried child [or unmarried child of Your Domestic Partner], under Age 19. An unmarried child who is a full-time student may be Covered until Age [26].[**For FL Residents: Dependent means a person who is designated by You who may become Covered or is entitled to benefits under the Plan if He is one of the following:**
- **Your spouse [or Domestic Partner] (if not legally separated or divorced from You); or**
- **Your child who is under Age 26 through the end of any calendar year, dependent on You for support and either living in Your household of a full-time or part-time student.]**

Child includes stepchildren, adopted children or foster children who are dependent upon You for support.

[For FL Residents: We may require proof of the child's enrollment as a full-time or part-time student.]

Full-time student means Your child who is attending an accredited college, vocational or high school, enrolled in sufficient courses to maintain full-time status and more than 50% dependent on the You for support and maintenance. Proof of the child's enrollment as a full-time student must be submitted to Us. Full-time student status will continue during school vacation if:

- the child was enrolled as a full-time student immediately prior to the vacation; and
- intends to return as a full-time student.]

[N/A for FL Residents: Disabled means: (1) Confined in a Hospital, Convalescent Facility, other residential medical treatment center, or at home under a Doctor's order; or (2) unable because of Injury or Sickness to engage in the usual activities of a person who is the same Age and gender.

[**Dismemberment** means:

- complete severance at or above the elbow or knee joint regarding arm or leg;
- complete severance at or above the wrist or ankle joint regarding hand or foot;
- the irrecoverable loss of the entire sight of one eye regarding sight;
- complete severance through or above the proximal phalanx regarding thumb and index finger;
- irrecoverable loss of speech which does not allow audible communication in any degree regarding speech;
- total and irrecoverable loss of hearing which cannot be corrected by any hearing aid or device regarding hearing;
- complete and irrecoverable paralysis of limbs when used with reference to quadriplegia, paraplegia and hemiplegia.]

Doctor means a person who is:

- licensed and recognized as a provider of medical services by the state in which He practices;
- recognized as a provider of medical services by the insurance law of the state in which the provider practices;
- acts within the scope of His license;
- gives treatment for which benefits are payable under the Plan; and
- not one of the following:
  - a person who ordinarily resides in the Covered Person's household;
  - a member of the Covered Person's immediate family; [or]
  - [another person of the Participating Entity.]

The definition of Doctor also includes a practitioner listed in the latest edition of the Christian Science Journal [**For FL Residents: and a certified nurse-midwife and midwives licensed pursuant to chapter 467.]**

[Domestic Partner means a person of the [opposite] [or] [same] sex with whom the person has established a Domestic Partnership.]

[Domestic Partnership means a relationship between You and one other person of the [opposite]

[or] [same] sex when all of the following requirements are met by You and Your Domestic Partner:

- are not related by blood or a degree of closeness that would prohibit marriage in the law of the state of residence;
- are not currently married to, or a Domestic Partner of, another person under either statutory or common law;
- share the same permanent residence and the common necessities of life;
- are at least 18 years of age;
- are mentally competent to consent to contract;
- are financially interdependent and furnish documents to support both of the following conditions of such financial interdependence:
  - have a single dedicated relationship of at least six months duration; and
  - have joint ownership of a residence;
- have at least two of the following:
  - joint ownership of an automobile;
  - joint checking, bank or investment account;
  - joint credit account;
  - lease for a residence identifying both parties as tenants; or
  - will and/or life insurance policies which designates the other as primary beneficiary.

You and Your Domestic Partner must jointly sign the required affidavit of Domestic Partnership.]

Emergency means the sudden onset of a medical condition manifested by symptoms of such severity that the failure to immediately provide Medically Necessary care could reasonably be expected to result in:

- placing Your health in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Experimental means care, treatment, services or supplies not approved or accepted as essential to the treatment of Injury or Sickness by any of the following:

- the American Medical Association;
- the United States Surgeon General;
- the United States Department of Public Health;
- the National Institute of Health; or
- Medicare.

He, His and Him also mean she, hers and her, respectively when referring to a female.

Hospital means an institution which meets these requirements:

- it mainly provides Inpatient medical care and treatment to injured or sick people;
- it has facilities on its premises for diagnosis;
- it has facilities on its premises for surgery. This requirement does not apply to an institution otherwise meeting the definition of "Hospital" if it has made arrangements with another institution for surgery for its patients;
- treatment is supervised by Doctors;
- it has 24 hour registered graduate nursing services; and
- it is licensed or is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations.

The term "Hospital" also includes a sanitarium accredited by The Commission for Accreditation of Christian Science Nursing Facilities, Inc. [**For FL Residents: a birthing center licensed under ss. 383.30-383.335, or an institution accredited by the Joint Commission on the Accreditation of Hospitals, the American Osteopathic Association, or the Commission on Accreditation of Rehabilitative Facilities if rehabilitation is specifically for treatment of physical disability.]**

Hospital does not include any of the following:
- a rest or nursing home, home for the aged or convalescent home;
- a skilled nursing facility or an extended care facility;
- a hospice or a place for Custodial Care, birthing center;
- a place for primarily treating Alcohol or Drug Abuse, [except as allowed under the Alcohol or Drug Abuse provision;] or
- a place for primarily treating Mental Illness [, except as allowed under the Mental Illness provision].

[For FL Residents: "Hours of Work Credit per Month" means:
- **for initial eligibility, the minimum number of hours You must work for the Sponsor in order to satisfy the Waiting Period and become eligible for Coverage under the Plan; or**
- **for continued eligibility, the numbers of hours You work for the Sponsor in the prior month which determine the level of benefits available to You during the current month.]**

Injury means trauma or damage to some part of the body caused solely by Accident and not contributed to by any other cause.

Inpatient means a registered bed patient who uses the room and board facilities of a Provider.

Intensive Care Unit or ICU means a unit of a Hospital which:
- is designed for patients in critical condition requiring care not available in regular care areas;
- is a separate and distinct area providing special nursing care and continuous observation; and
- provides a concentration of special life-saving equipment immediately available for critical patients.

It includes a "Coronary Care Unit" or "CCU" which meets the above requirements.

Master Policy means an insurance policy issued to an entity establishing an insurance plan.

Medically Necessary means that a service, drug, or supply is needed for the diagnosis or treatment of an Injury or Sickness in accordance with generally accepted standards of medical practice in the United States at the time of the service, drug or supply is provided. A service, drug or supply shall be considered "needed" if it: (a) is ordered by a licensed Doctor; and (b) is commonly and customarily recognized through the medical profession as appropriate for the particular Injury or Sickness for which it was ordered. A service, drug or supply shall not be considered as Medically Necessary if it is investigational, Experimental, or educational.

[For FL Residents: Medically Necessary means any services or supplies provided for the diagnosis and treatment of a specific Sickness or Injury which are:
- **ordered or recommended by a Doctor;**
- **required for the treatment or management of a medical condition or symptom;**

- **the most appropriate supply or level of service which can safely be provided to the Covered Person;**
- **provided in accordance with approved and generally accepted medical or surgical practice; and**
- **furnished in the least intensive type of medical care setting required by the Covered Person's condition.**

Services and supplies will not be automatically be considered Medically Necessary because they were ordered by a Doctor.]

Medicare refers to the benefits provided under Part A and Part B of Title XVIII of the Federal Social Security Act.

Mental Illness means anything classified as a mental disorder in the International Classification of Diseases 9th Revision, Clinical Modification, Volume I, (ICD-9-CM), as it now exists or as amended from time to time, other than conditions classified therein as dependency or abuse of alcohol or drugs.

[**Natural Tooth** means the major portion of an individual tooth is present, regardless of fillings, and is not abscessed or defective.]

[**Necessary** means dental care that is:
- Required to maintain generally accepted dental health;
- Recommended by a Dentist; and
- Commonly recognized in the dental profession as acceptable treatment for the condition.]

Occupational Injury Or Sickness means an Accidental bodily Injury or Sickness that arises out of or in the course of any work for pay or profit.

Participant means any person that has obtained Coverage under the Master Policy.

Participating Entity means any group that has obtained coverage under the Master Policy.

Plan means the benefits described in this document which are provided under the Master Policy.

Pre-Existing Condition means a Sickness or Injury for which:
- diagnosis has been made;
- treatment has been recommended;
- treatment has been rendered; or
- expenses have been incurred

within [6-24] months prior to becoming Covered under the Plan.

[**For FL Residents Only: It includes any condition manifesting itself in symptoms which would cause an ordinarily prudent**
person to seek medical advice, diagnosis, care or treatment.
The definition of "Pre-Existing Condition" may not include routine follow up care for a breast cancer patient who has been previously determined to be free of breast cancer unless evidence of breast cancer is found during or as a result of such follow up care.]

Prior Plan means any group or group enrollment insurance policy, medical service plan, employee welfare plan or trust, or other group-type arrangement, under which You were covered [through the Participating Entity] and which was in effect immediately preceding the effective date of this Plan.

Provider means any person or health care facility duly licensed or legally authorized to render care or services Covered under the Plan.

Sickness means an illness, disease, complication of pregnancy or normal pregnancy.

[Temporomandibular Joint (TMJ) Syndrome means the symptoms associated with, or exhibited as a malfunction of, the temporomandibular joint. These are frequently caused by, but not exclusive to:

- Improper or incorrect space between the maxilla and mandible;
- Improper dental occlusion; and
- Muscular spasm in the TMJ area.]

[**Treatment Plan** means a written statement on a form satisfactory to Us in which the Provider lists:

- his findings from an examination of the Covered Person;
- his suggested plan of treatment; and
- the approximate cost and duration of such treatment.]

[**Waiting Period** means the [period of time][minimum number of Hours of Work Credit Per Month which must elapse] following the employee's date of hire before being eligible for Coverage under the Plan as indicated on the Schedule of Benefits Page.]

We, Us, Our or Company refers to Markel Insurance Company.

You or Your means the eligible individual whose Coverage is evidenced by this certificate.

Disposition for MRKC-126829991

SERFF Tracking Number:	MRKC-126829991	**State:**	Virginia
Filing Company:	Markel Insurance Company	**State Tracking Number:**	
Company Tracking Number:	MAG100T-VA (09/10)		
TOI:	H21 Health - Other	**Sub-TOI:**	H21.000 Health - Other
Product Name:	Makel Basic Health Insurance		
Project Name:	Markel Basic Health Insurance		

Disposition Date: 02/07/2011

Implementation Date:

Status: Approved

Comments:

Schedule Items

Item Type	Item Name	Item Status	Public Access
Supporting Document	PPACA Uniform Compliance Summary	Received & Acknowledged	Yes
Supporting Document	L&H Readability - Health	Received & Acknowledged	Yes
Supporting Document	Forms Listing	Received & Acknowledged	Yes
Supporting Document	Discretionary Group Certification	Received & Acknowledged	Yes
Supporting Document	Previous Filing Approvals	Received & Acknowledged	Yes
Supporting Document	Red Line Documents		No
Supporting Document	*Red Line Documents*	*Received & Acknowledged*	*Yes*
Supporting Document	FL Redline version	Received & Acknowledged	Yes
Supporting Document	*FL Redline version*	*Received & Acknowledged*	*Yes*
Supporting Document	Incontestability RedLine Documents	Received & Acknowledged	Yes
Form	MAG100T-VA (09/10), Policy/Contract/Fraternal Certificate, LIMITED BENEFIT INSURANCE- Master Policy	Approved	Yes
Form	*MAG100T-VA (09/10), Policy/Contract/Fraternal Certificate, LIMITED BENEFIT INSURANCE- Master Policy*	*Withdrawn*	*Yes*
Form	*MAG100T-VA (09/10), Policy/Contract/Fraternal Certificate, LIMITED BENEFIT INSURANCE- Master Policy*	*Withdrawn*	*Yes*
Form	MAG123T-VA (09/10), Application/Enrollment Form, Application	Approved	Yes

Form	MAG128T-VA (09/10), Other, Blank Amendatory Endorsement	Approved	Yes
Form	MAG200T-VA (09/10), Certificate, LIMITED BENEFIT INSURANCE - Certificate of Insurance	Approved	Yes
Form	*MAG200T-VA (09/10), Certificate, LIMITED BENEFIT INSURANCE - Certificate of Insurance*	*Withdrawn*	*Yes*
Form	*MAG200T-VA (09/10), Certificate, LIMITED BENEFIT INSURANCE - Certificate of Insurance*	*Withdrawn*	*Yes*
Form	*MAG200T-VA (09/10), Certificate, LIMITED BENEFIT INSURANCE - Certificate of Insurance*	*Withdrawn*	*Yes*
Form	MAG402T-VA (09/10), Application/Enrollment Form, Enrollment Form	Approved	Yes